

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155616	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
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NAME OF PROVIDER OR SUPPLIER  ROBERT E LEE	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Compliant IN00195157.</p> <p>Survey dates: March 2, 3, 4, 7, 8, 9 and 10 2016</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Census bed type: SNF/NF: 84 Residential: 13 Total: 97</p> <p>Census payor type: Medicare: 9 Medicaid: 50 Other: 25 Total: 84</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0241 SS=D Bldg. 00	<p>March 16, 2016.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's dignity was maintained during meal observation for 6 of 14 residents in the 4 Hall Dining Room and 7 of 11 residents in the 1-2-3 Hall Dining Room, and the facility failed to ensure the dignity of the resident while care was being provided for 1 of 2 residents observed for dignity. (Residents # 92, M, N, O, P, F, Q, G, H, E, L, K, I and J).</p> <p>Findings include:</p> <p>A. On 03/02/2016 at 12:06:41 p.m., during the initial tour, Resident # P, Resident # M, and Resident # N was observed in Hall 4 Dining Room waiting for ten to fifteen minutes before receiving lunch service. Residents at the same table were already eating and finishing up lunch.</p> <p>On 03/03/2016 at 12:25:22 p.m., during an observation, Resident # M, # Resident</p>	F 0241	<p>1.A. Meal Service will be reviewed and revised to ensure the residents affected (M,N,O,P,F,Q,G,H,E,L,K,I and J) will receive their meal trays in a systematic and timely manner.</p> <p>B. Resident #92 has expired</p> <p>2.A. As all residents may have the potential to be affected the policy for meal service will be reviewed and revised to ensure all residents are served their mealtrays in a systemic and timely manner.</p> <p>B. No other Residents were affected</p> <p>3.A. The meal service policy/procedure has been revised to ensure a systematic and timely tray delivery process is in place. The dietary staff and Nursing staff will be in-serviced on the new dining policy and the importance of.</p> <p>B. The nursing staff have been in-serviced on providing privacy and dignity when providing care.</p> <p>1. A. A department manager will be assigned to the individual dining rooms during 2 random</p>	04/08/2016			

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	<p># N, and Resident # O was observed sitting at a table in the Hall 4 Dining Room waiting for their lunch trays at 12:00 p.m. Resident # M received the lunch tray at 12:26 p.m. Resident # M indicated "I am sitting here waiting on my tray and I don't know why it's not here yet". Resident # N received the lunch tray at 12:27 p.m. and Resident # O received the lunch tray at 12:29 p.m. Several residents were observed finishing up their meal.</p> <p>On 03/07/2016 at 12:49 p.m, Resident # P was observed sitting in a wheelchair at the lunch table, with head laying on the table, waiting for the lunch tray at 11:50 a.m. Resident # P received the lunch tray at 1:11 p.m.</p> <p>On 03/07/2016 at 12:54 p.m., Resident # O indicated, " I have been out here since 12:00 p.m. waiting on my tray. I just sit here and watch all of these people. I don't know why it's not here yet." During an observation in the Hall 4 Dining Room the staff started serving the lunch trays at 12:50 p.m.</p> <p>On 03/07/2016 at 1:00 p.m., Resident # Q indicated to the ADON (Assistant Director of Nursing) " I have sit here all day and you are finally going to feed me." The ADON was providing the resident</p>		<p>meals Monday – Friday to ensure compliance daily x2weeks, weeklyx4 andmonthly x4. Any areas of concern will be addressed immediately. The QAmonitoring tool will be reviewed in the daily AM management meeting andforwarded to the QA committee to review for compliance, the need for furtherpolicy/procedure revisions and/or staff education.</p> <p>B. The DON and/or Designee willmake 2 random rounds daily Monday - Friday to ensure privacy is being providedduring care daily x2weeks, weekly x4 and monthly x4. Any areas of concern willbe addressed immediately. The QA monitoring tool will be reviewed daily duringthe AM management meeting and forwarded to the QA committee to review forcompliance, the need for further policy/procedure revisions and/or staffeducation</p>				

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	<p>with a clothing protector at this time. B. During lunch observations of the 1-2-3 Dining Room on 3/2, 3/3, 3/4, 3/5 and 3/7/16, the following was observed:</p> <p>1. Initial dining room observation on 3/2/16 between 12:00 Noon and 12:45 p.m.:</p> <ul style="list-style-type: none"> <li>- trays were not being served consecutively in that one table was not completed before moving onto the next table. Resident #L sat for 22 minutes before being served while others received their trays. Resident # L was observed to be looking around at the other tables and his tablemates who were eating while he waited. Trays were also being taken to resident rooms on the hall while the dining room was served.</li> </ul> <p>2. On 3/3/16 between 12:00 p.m. Noon and 12:30 p.m.:</p> <ul style="list-style-type: none"> <li>- 1st tray was taken to Resident # K at Noon, second tray to Resident # I at 12:02 p.m., Resident # L received his tray at 12:07 p.m. and Resident # J received his tray at 12:12 p.m.; both were looking around at their tablemates while they waited on their tray.</li> <li>- All 3 residents at Resident # F's table received their trays at Noon except her. She then received her tray at 12:07 p.m. Resident # F was observed to be looking at her tablemates while she waited on her tray. The CNAs (Certified Nursing</li> </ul>			

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	<p>Assistants) were observed to be taking trays to resident rooms in between serving the dining room tables.</p> <p>3. During interviews with Residents # L and # J on 3/4/16 at 8:45 a.m., Resident # L indicated "I am always the last one served at meals - I have no clue as to why. Hate sitting there watching while everyone else eats." Resident # J also indicated "This happens to us a lot - they are so disorganized. I also have to wait on my meal while the others at my table are eating and then you have to ask for condiments; there is no order as to who gets their tray."</p> <p>4. On 3/5/16 at 12:25 p.m., Resident # L was observed sitting at his table waiting on his food tray - all 3 of his tablemates were eating their meals. Resident # I was observed to give Resident # L his roll while he waited. Staff were observed fixing trays for residents at other tables and taking trays to residents who were eating in their rooms before Resident # L received his tray at 12:35 p.m.</p> <p>In an interview with LPN #1 at 12:45 p.m., she indicated "There really is no order to when the trays come up on the food cart, sometimes they may be in room order and then other times they are mixed."</p>			

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	<p>5. During an interview with Cook #1, the Dietary Manager and Dietary Aide #1 on 3/7/16 at 11:50 a.m., the Cook indicated "The dining room carts are fixed first, then the next cart is the hall trays. The 1-2-3 dining room cart is fixed and sent out, then 1-2-3 Hall cart is fixed and then sent out. Hall 4 dining room and hall carts are done the same way. They are also fixed according to tables - all one table is to be served before moving on to next table."</p> <p>6. On 3/7/16 at 12:20 p.m., the hall trays were observed being served at the same time as the dining room trays.</p> <ul style="list-style-type: none"> <li>- Resident # I received his tray at 12:20 p.m., Resident # J received his at 12:21 p.m., Resident # K received his at 12:25 p.m. Resident # K was observed to give Resident # L his mighty shake while everyone else at the table was eating and he was waiting on his tray. At 12:35 p.m., Resident # L received his food tray which was on the second cart of trays.</li> <li>- In an interview at 12:38 p.m., CNA #2 indicated "There is no specific order when the trays come up from the kitchen. I personally like to serve the men first as they can be more impatient than the others. We are supposed to serve the whole table first before moving on to the next table and complete the dining room</li> </ul>			

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	<p>before moving to the hall trays."</p> <p>On 3/8/16 at 1:08 p.m., the Dietary Manager presented a copy of the facility's current policy titled "Meal Service". Review of this policy at this time included, but was not limited to: "Meal Service: Purpose: to ensure each resident is provided with the daily menu choices and have their meals served in a location of their choice....5. Meals trays will be served in the dining rooms first and then the room trays will be delivered..."</p> <p>C. On 03/03/16 between 11:48 a.m., and 12:30 p.m., the observation of the 1-2-3 Hall Dining Room lunch service, indicated the meal cart to arrive at 11:58 a.m., with 11 residents present. The food was uncovered at 12:00 p.m., for Resident # E and placed on the table. The resident was not present in the dining room at this time. At 12:20 p.m., the resident was notified of the lunch meal service, after the Nurses Aide student # 1 was asked whose plate was at the table. The resident arrived within a minute of being told of the meal service. The Nurses Aide student was told the food was probably cold and the student requested for Nurses Aide student # 2 to return the food to the kitchen for a warm tray. The resident left the dining room when the cold food was returned to the kitchen. The resident returned to the</p>						

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	<p>dining room and the Nurses Aide student # 2, returned with a tray at 12:27 p.m.</p> <p>On 03/07/16 at 12:20 p.m., the lunch meal service began in the 1, 2, 3 Hall Dining Room. At 12:27 p.m. 3 of 4 residents were served by an unknown Nurses Aide student # 3 at the same table. Resident # F was at this table and waited until 12:33 p.m. to be served the lunch tray. At another table at 12:27 p.m., an unknown resident was served, then another resident at this table was served at 12:32 p.m. Resident # G at this table was served at 12:39 p.m. At 12:37 p.m., Resident # H left the lunchroom when the lunch tray wasn't served and 6 other residents were served at the same table. The resident returned to the dining room 2 minutes later and waited until 12:43 p.m. to be served the meal tray.</p> <p>D. During an observation of Resident #92 on 3/3/16 at 2:55 p.m., CNA (Certified Nursing Assistant) #1 was providing care to Resident #92. Resident #92 had his legs exposed and was not covered up. The privacy curtain was not closed and the door was open. Resident #92 could be seen directly from the hallway.</p> <p>During an interview with the DON (Director of Nursing) on 3/4/16 at 1:00 p.m., she indicated Resident #92 should have had his privacy curtain closed and</p>			
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F 0371 SS=E Bldg. 00	<p>door closed while care was being provided to the resident.</p> <p>The DON provided a copy of the current policy/procedure, dated 11/2011, titled "Resident Privacy", on 3/10/16 at 9:11 a.m. This document included, but was not limited to, the following: "... 4. Doors, curtains and privacy curtains shall be closed during Resident care activities to provided full visual privacy..."</p> <p>3.1-3(t)</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>Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were maintained related to food and drink service to 6 of 11 residents (Residents # 89, 48, 74, 26, 105 and 31) observed in the 1-2-3 Hall Dining Room and Resident Rooms.</p> <p>Findings include:</p> <p>The observation on 03/07/16 at 12:05 p.m., of the 1-2-3 Hall Dining Room lunch service indicated CNA(Certified</p>	F 0371	<p>1.Residents (89,48,74,26,105 and 31) had noadverse reactions.</p> <p>2.No other residents were affected</p> <p>3.The nursing staff were in-serviced on properhand washing including hand washing during meal service.</p> <p>4.A department manager will be assigned to theindividual dining rooms during 2 random meals Monday-Friday to ensure properhand washing takes place, daily x2weeks, weekly x4 and monthly x4. Any areas ofconcern will be addressed immediately. The QA monitoring tool will be revieweddaily during the AM</p>	04/08/2016

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	Nursing Assitant) # 1 pushed trash into the trash can, and without washing her hands, obtained a washcloth and washed down the table. The CNA then scooped ice from the cooler and placed it into a glass for Resident # 89. She then picked up the washcloth and wiped down the table again. She touched Resident # 48 on the shoulder and coughed into her hands. The CNA walked over to Resident # 74 and placed a clothing protector on the resident. The CNA obtained another clothing protector and placed it onto Resident # 26. She walked over to Resident # 105 and pushed the geri chair into the dining room and adjusted its' position, touching the resident on the shoulder. She then picked up a cup of lemonade for the resident and placing it in the hand of the resident. The CNA picked up debris from the dining room floor and walked over to the serving table, placing the debris on the table. She touched the lids on the pitchers of ice and placed a tray of styrofoam cups onto the cart. The CNA placed her fist onto her mouth. She then held onto the cart handle, coughed into her hand, and placed her hands onto her chin while talking to other staff. She coughed into her hands twice, while sitting down on a stack of chairs. She then coughed into her right hand and picked up a cup to deliver to Resident #		management meeting and forwarded to the QA committee to review for continued compliance and the need for policy/procedure revisions and/or additional educational needs.	

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	<p>31. She brought a cup out of the resident's room and threw it away. The CNA entered the lounge room, then exited using hand sanitizer.</p> <p>During an interview with the Dietary Manager on 03/08/16 at 2:20 p.m., she indicated the staff should wash their hands or use hand sanitizer after serving food or drink to 2-3 residents.</p> <p>During an interview on 03/10/16 at 1:40 p.m., the DON (Director of Nursing) indicated the staff should wash their hands after serving 2-3 residents and wash their hands every time they touch a resident. She also indicated the staff should wash their hands after handling trash.</p> <p>On 03/08/16 at 10:57 a.m., the DON provided a copy of the facility policy on HANDWASHING which indicated: Policy:.... Hand washing during Meal Time Alcohol based hand rub may be used between serving every 3rd tray. Hands must be washed following the Hand washing procedure if: contact with a resident is made during the meal pass. Hands must be washed prior to feeding a resident if soiling of hands has occurred or resident contact has been</p>			

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F 0431 SS=E Bldg. 00	<p>made. Otherwise alcohol based hand rub may be utilized.</p> <p>3.1-21(3)</p> <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</p>			

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	<p>dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to label medications properly, store the medications following the manufacturer, pharmacy, or supplier recommendations, store personal food in the appropriate locations, and store medications in the correct resident's labeled container. This deficient practice affected 6 of 7 medication carts. (Resident #48, #63, #70, #76, #89, and #111)</p> <p>Findings include:</p> <p>During the medication storage observation on the 1 Hall medication cart, with LPN (Licensed Practical Nurse) #1, on 3/07/16 at 9:25 a.m., the following was observed:</p> <ol style="list-style-type: none"> <li>Observed in the bottom of the medication storage drawer were 4 loose pills.</li> <li>Observed in a drawer next to Resident #111's 4 bottles of Glycol powder, was a small sharps biohazard container, which contained used sharps.</li> </ol> <p>During the medication storage observation on the 3 Hall Split medication cart, with LPN (Licensed Practical Nurse) #1, on 3/07/16 at 9:36</p>	F 0431	<ol style="list-style-type: none"> <li>The outdated/undated insulin was discarded and replaced immediately. The loose pills were disposed of immediately. The unlabeled medications were addressed immediately and the pharmacy notified. Residents (48,63,70,89 and 111) had no adverse reactions</li> <li>No other residents were affected</li> <li>The nurses/QMAs were in-serviced on proper medication storage and labeling/dating. The nurses/QMAs will utilize a cart transfer form at the change of each shift which will indicate that each medication cart has been checked for properly dated/labeled and expired medications, including loose pills.</li> <li>The medication cart transfer form will be reviewed by the DON/Designee daily x2 weeks, weekly x4 and monthly x4. The medication cart transfer form will be turned into the DON monthly. A QA audit form will be developed and the DON/Designee will do complete medication cart audits weekly x4 and monthly x5 to ensure compliance. The QA form will be reviewed daily in the AM management meeting as completed and forwarded to the QA committee to review for continued compliance and the need for policy/procedure revision and/or further staff education.</li> </ol>	04/08/2016			

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	<p>a.m., the following was observed:</p> <p>3. Observed in the bottom of the medication storage drawer were 10 loose pills.</p> <p>4. Observed in the top drawer were 2 opened bottles of Resident #76's Lantus Insulin bottle, one opened bottle of Resident #76's Humalog insulin, and one opened bottle of Resident #89's Novolog insulin, all bottles did not have an open date.</p> <p>5. Observed in the bottom of the drawer were five Iferex 150 mg capsules in the package, with no name on the package.</p> <p>During the medication storage observation on the 2/3 Hall medication cart, with LPN #3, on 3/07/16 at 9:52 a.m., the following was observed:</p> <p>6. Observed in the top drawer was an open applesauce cup along with residents ' medications.</p> <p>7. Observed in the top drawer, Resident #70's Lantus Solostar insulin pen was in Resident #48's Lantus Solostar insulin pen medication bag.</p> <p>8. Observed in the bottom of the medication storage drawer were 9 loose</p>			

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	<p>pills.</p> <p>During the medication storage observation on the 4 Long Hall medication cart, with RN (Registered Nurse) #1, on 3/07/16 at 10:04 a.m., the following was observed:</p> <p>9. In the top drawer was a staff member 's package of devil food cake cookies.</p> <p>10. Resident #63's Lantus Insulin vial had an open date of 2/2/16, and had a label that indicated discard unused medication after 28 days. Resident #63 also had a vial of Humalog insulin opened on 2/2/16.</p> <p>11. Observed in the bottom of the medication storage drawer were 3 loose pills.</p> <p>During the medication storage observation on the 4 Short Hall medication cart, with RN (Registered Nurse) #1, on 3/07/16 at 10:12 a.m., the following was observed:</p> <p>12. In the top drawer was a package of Cefdinir 125 mg with no resident name on the package.</p> <p>13. Observed in the bottom of the medication storage drawer were 6 loose</p>				

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	<p>pills.</p> <p>During the medication storage observation on the 5 Hall medication cart, with the Assistant Director of Nursing, on 3/07/16 at 10:18 a.m., the following was observed:</p> <p>14. Observed in the bottom of the medication storage drawer were 3 loose pills.</p> <p>An interview on 3/27/2015 at 11:34 a.m., with the Director of Nursing (DON), confirmed all above issues. The DON indicated the pharmacist makes monthly checks on the medications carts and the nurses working the floor should check them as needed. The DON indicated all medications in the carts should be labeled with resident identifiers and stored in the correct resident medication bag/container. The DON indicated all expired medications should not be the cart. The DON indicated no personal staff food should be located in the medication carts. The DON indicated the medications should be stored and dated per manufacturer, pharmacy, or supplier recommendations.</p> <p>A policy, dated 9/15 and titled, " Medication Storage " was provided by the DON on 3/8/2016 at 10:57 a.m. and</p>				

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F 0460 SS=E Bldg. 00	<p>was identified as current. This document included, but was not limited to, the following: "... 4. Oral medications in a pill form are kept in the medication cart area designated to the Resident... 8. All outdated medications will be destroyed per State and Federal Guidelines..."</p> <p>3.1-25(j)(k)(l)(m) 3.1-25(o)</p> <p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based on observation and interview, the facility failed to ensure resident bedrooms and shower/bathrooms had full visual privacy, in that curtains were missing, were too short when pulled around the resident bed, and/or were hanging off the ceiling tracks. This deficient practice affected 6 of 35 resident rooms observed. (Rooms 27, 44B, 49B, 53A and B, and 47A).</p> <p>Findings include:</p>	F 0460	<p>1.All areas identified were addressed andcorrected immediately. No Residents had adverse reactions related to thisfinding</p> <p>2.No other Residents were affected</p> <p>3.A complete tour of the facility will beconducted by the Administrator, Maintenance Director and Housekeeping Directorany areas of concern will be addressed immediately. The Maintenance Directorand Housekeeping Director will make weekly rounds and forward to theAdministrator any areas of</p>	04/08/2016

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	<p>During initial tour of the resident rooms on 3/4/16 between 9:10 a.m. and 10:00 a.m., the following was observed:</p> <p>1. Room 27 - the shower curtain inside the front of the bathroom was missing - this room also served as the resident's shower room; if the door was opened, the resident would be exposed. Interview with Resident #70 at this time indicated she worried about that as she was a very private person.</p> <p>2. Room 44B - when the bedside curtain was pulled around the bed, there was a 3 foot gap which prevented full visual privacy. There also was no shower curtain inside the bathroom door to assure visual privacy if the door should be opened.</p> <p>3. Room 49B - when the bedside curtain was pulled around the bed, there was a 6 foot gap which prevented full visual privacy. 1 foot of the curtain had hooks, but was hanging down off the track. 1 foot of the curtain in the middle had no hooks to attach to the track, and multiple small holes were also noted in the top mesh of curtain.</p> <p>4. Room 53B - 4 feet of the bedside curtain was hanging down off of the track - hooks were in the curtain but not on the track; shower curtain was missing inside</p>		<p>concern and corrections made on a continuous basis.</p> <p>4. The Administrator will make rounds with the Maintenance Director and the Housekeeping Director weekly x4, monthly x5 to ensure compliance. Then quarterly thereafter. The QA tool will be reviewed in the daily AM management meeting and forwarded to the QA committee to review for continued compliance and the need for policy/procedure revisions and/or staff education.</p>	

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F 0465 SS=E Bldg. 00	<p>the front of the bathroom door - resident would be exposed if the door was opened.</p> <p>5. Room 53A - the shower curtain was missing inside the front of the bathroom door - resident would be exposed if the door was opened.</p> <p>Interview with Residents #57 and #111 at this time indicated these things have been like this for awhile and that it did no good to complain.</p> <p>6. Room 47A - the shower curtain inside the bathroom door would not pull across the rod to ensure visual privacy when the door was opened.</p> <p>During an interview with the Housekeeping Director on 3/8/16 at 10:30 a.m., she indicated that some of the bathrooms did have a shower curtain but they were in the wrong place to assure visual privacy if the bathroom door was opened.</p> <p>3.1-19(1)(6) 3.1-19(1)(7)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p>			

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	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, record review, and interview, the facility failed to provide maintenance and housekeeping services to keep the facility clean and in good repair. This deficient practice affected 11 of 97 residents in the building. (Resident's #25, #29, #36, #49, #59, #64, #77, #83, #87, #90, and #91.)</p> <p>Findings include:</p> <p>During the initial tour on 3/2/16 at 12:06 p.m. and during the environmental tour on 3/9/16 at 11:28 a.m., with the Maintenance Supervisor, the following observations were made:</p> <p>1. Observations in Room 17: In the bathroom the middle ceiling tile was loose and off the track by 2 inches. In the room, above the bed, were 11 small brown spots on the ceiling.</p> <p>2. Observations in room 103: Six tiles were cracked in front of and under the bed. One crack on the floor measured 2 inches by 1/2 inch and 1/8 inch deep.</p> <p>3. Observations in room 106: Yellowish brown sticky substance on ground that measured 3 feet by 1 foot. Four tiles under the bed and to the right of the bed were cracked and discolored, one crack</p>	F 0465	<p>1. All areas identified were addressed and corrected immediately. No Residents had adverse reactions related to this finding</p> <p>2. No other Residents were affected</p> <p>3. A complete tour of the facility will be conducted by the Administrator, Maintenance Director and Housekeeping Director any areas of concern will be addressed immediately. The Maintenance Director and Housekeeping Director will make weekly rounds and forward to the Administrator any areas of concern and corrections made on a continuous basis.</p> <p>4. The Administrator will make rounds with the Maintenance Director and the Housekeeping Director weekly x4, monthly x5 to ensure compliance. Then quarterly thereafter. The QA tool will be reviewed in the daily AM management meeting and forwarded to the QA committee to review for continued compliance and the need for policy/procedure revisions and/or staff education.</p>	04/08/2016

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	<p>measured 2 inches by 1 inch. The wall air unit cover was pulled away for one inch from the air unit.</p> <p>4. Observations in room 107: In the bathroom in front of the toilet was a yellow stain measuring one foot by one foot. Also in the bathroom is a crack in the ceiling measuring 6 inches by 1/4 of an inch.</p> <p>5. Observations in room 110: In the bathroom the light shade had a brown smear on it, and in the light shade there were too numerous bugs to count.</p> <p>6. Observations in room 111: In the bathroom the metal track in ceiling above the shower was rusted, measuring 5 inches by 1 inch. In front of the shower the tile was pulling up from the floor, measuring 1 foot by 3 inches. In front of the bed in the room, the tile was cracked, measuring 3 feet by 6 inches.</p> <p>7. Observation in room 119: In the bedroom the base board was coming off the wall, measuring 6 inches.</p> <p>8. Observations in room 121: The ceiling in the bathroom had a 3 foot by 2 foot water stain. On both sides of the wall air unit were cracks measuring 11 inches. Above the window was a crack</p>			

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	<p>in the wall measuring 1 foot. Two dark spots on the ceiling in the bedroom measured 3 inches by 2 inches.</p> <p>9. Observations in room 202: In the bedroom the air unit cover was missing. In the ceiling seven pencil sized holes were observed. Two brown stains on the ceiling in front of the ceiling unit. In the bathroom behind the toilet 5 inches of base board was pulling away from the wall.</p> <p>During an interview while on the environmental tour observation on 3/9/16 at 11:28 a.m., with the Maintenance Supervisor, he acknowledged all above issues.</p> <p>During an interview on 3/9/16 at 12:20 p.m., with the Maintenance Supervisor, he indicated he knew of most of the issues but just has not had the time to get around to fixing them. He indicated he does an audit on all the rooms.</p> <p>The Administrator provided a copy of the current policy/procedure, dated 10/01/2012, titled "Environmental Standards", on 3/10/16 at 9:11 a.m. This document included, but was not limited to, the following: "... The company recognizes the resident's needs and understands the importance of addressing</p>			

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R 0000 Bldg. 00	<p>the issues while maintaining a homelike atmosphere. This ensures the safety of residents, staff, and visitors, while maintaining the residents' comfort and dignity..."</p> <p>3.1-19(f)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 13 Sample: 5</p> <p>Robert E Lee was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure survey.</p>	R 0000		