

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155549	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2015
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NAME OF PROVIDER OR SUPPLIER  WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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F 0000  Bldg. 00	<p>This survey was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: October 13, 14, 15, 16, 19, 2015</p> <p>Facility number: 000681 Provider number: 155549 AIM number: 100286100</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 2 Medicaid: 32 Other: 10 Total: 44</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on October 26, 2015.</p>	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0323	483.25(h)			

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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SS=E Bldg. 00	<p><b>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>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.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure staff was knowledgeable regarding safety needs for residents with low air loss mattresses and developed practices and care plans based on manufacturer's safety recommendations for low air loss mattresses for 4 of 4 residents reviewed for the safe use of low air loss mattress and the use of full side rails (Residents #1, #27, #18 and #33).</p> <p>B. Based on interview and record review, the facility failed to ensure blood sugar monitoring was completed at the time of a fall as part of the post fall investigation for 2 of 3 residents reviewed for accidents. (Resident #37 and #35)</p> <p>Findings include:</p> <p>A1. Resident #1's clinical record was reviewed on 10/15/15 at 1:57 p.m. Resident #1's diagnoses included, but were not limited to, anemia, Parkinson's disease and depression. Resident #1 had a current, 4/24/15, physician's order for a</p>	F 0323	<p>A1. Residents #1, #27, #18, and #33 did not experience any negative outcomes for the alleged deficient practice. Manufacturer's instructions for each low air loss mattress in use has been obtained by the facility. Each resident's side rail screen and care plan has been reviewed and revised to reflect the safety needs of the resident. Nursing staff has been educated on the safety needs of the residents with low air loss mattresses. A2. Any resident using a low air loss mattress has the potential to be affected. The manufacturer's instructions for the low air loss mattress has been obtained by the facility. Each resident's side rail screen and care plan has been reviewed and revised to reflect the safety needs of resident. Nursing staff has been educated on the safety needs of the residents with low air loss mattresses (See Attachment). A3. The nursing staff has been educated on the safety needs of the residents utilizing low air loss mattresses. A safety review form has been implemented (See Attachment). A4. The DON or designee will be responsible for completing the safety review form</p>	11/18/2015

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	<p>low air loss mattress with full side rails per manufacturer's recommendations.</p> <p>Resident #1 had a, 8/4/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident usually understood, required cueing and assistance when making decisions, was totally dependent on staff for bed mobility and had impaired range of motion in both her upper and lower extremities.</p> <p>Resident #1 had a, 6/11/15, care plan problem/need regarding the use of 2 full side rails.</p> <p>Resident #1 had a, 6/18/15, "Side Rail Screen" which indicated "has full rails due to manufacture recommendation for low air loss."</p> <p>Resident #1 was observed in her bed with a low air loss mattress and side rails up on both sides of the bed on 10/16/15 at 4:01 p.m.</p> <p>During a 10/14/15, 9:51 a.m., interview, the Assistant Director of Nursing indicated Resident #1 used a low air loss mattress with full side rails due to the manufacturer's recommendation for full side rail use for safety.</p>		<p>on scheduled work days as follows: daily for two weeks, weekly for four weeks, then monthly thereafter to ensure blood sugars have been checked for any diabetic resident who experiences a fall. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated B1. Residents #35 and #37 did not experience any negative outcomes from the alleged deficient practice. The physician and POA of each resident was updated on the findings. Any falls the residents have experienced, the blood sugars have been taken and documented. B2. Any diabetic resident has the potential to be affected. If a diabetic has experienced any falls, the blood sugars have been taken and documented. B3. The facility's policy on accident and incident reporting t has been reviewed and no changes are indicated at this time (See Attachment). The nurses and QMAs will be re-educated on the policy with special focus on completing a blood sugar check on any diabetic resident who experiences a fall (See Attachment). A safety review form has been implemented (See Attachment). B4. The DON or designee will</p>				

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	<p>During a 10/14/15, 2:30 p.m., interview, the Director of Nursing and the Assistant Director of Nursing indicated Resident #1 used a "SenTech Sentry 1250 or Sentry 1400" low air loss mattress.</p> <p>A2. Resident #27's clinical record was reviewed on 10/16/15 at 4:06 p.m. Resident #27's diagnoses included, but were not limited to, debility, diabetes mellitus and cardiovascular accident. Resident #27 had a current, 4/17/14, physician's order for "may have low air loss mattress with full side rails-manufactures recommendations."</p> <p>Resident #27 had a 8/10/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was rarely or never understood/understands, rarely or never made decisions, was totally dependent on staff for bed mobility and had impaired range of motion in both her upper and lower extremities.</p> <p>Resident #27 had a, 6/11/15, care plan problem/need regarding the need for side rails for tactile bed boundaries. Approaches to this problem included, but were not limited to, "low air loss mattress 2 full rails according to manufactures instructions...."</p> <p>Resident #27 had a, 12/4/14, "Side Rail</p>		<p>be responsible for completing the safety review form on scheduled work days as follows: daily for two weeks, weekly for four weeks, then monthly thereafter to ensure blood sugars have been checked for any diabetic resident who experiences a fall. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>	

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	<p>Screen" which indicated 2 full side rails were used per manufacturer's guidelines for a low are loss mattress. "Cognitive Skills Review: Per resident interview, the resident displays cognitive ability which indicates the side rails can be successfully enabling to the resident without risk of injury-NO"</p> <p>Resident #27 was observed in bed on a low air loss mattress with full side rails up on both sides of the bed on 10/14/15 at 9:40 a.m., 10/15/15 at 9:43 a.m., 10/16/15 at 4:03 p.m. and 10/19/15 at 8:34 a.m.</p> <p>During a 10/14/15, 9:53 a.m., interview, the Assistant Director of Nursing indicated Resident #27 used a low air loss mattress and full side rails because the full side rails were recommended by the mattress manufacturer for safety.</p> <p>During a 10/14/15, 2:30 p.m., interview, the Director of Nursing and the Assistant Director of Nursing indicated Resident #27 used a "SenTech Sentry 1250 or Sentry 1400" low air loss mattress.</p> <p>A "SenTech, Sentry 1250 &amp; 1400" manual for a low air loss mattress, provided by the Director of Nursing (DON) on 10/14/15 at 2:30 p.m., did not contain any recommendations for full</p>			

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	<p>side rail use with the air loss mattress. During an interview on 10/15/15 at 2:30 p.m., the DON indicated the manufacturer did not make a recommendation for full side rails. She additionally indicated Resident #1 and #27 were currently using this style of low air loss mattress with full side rails in use.</p> <p>A3. Resident #18's clinical record was reviewed on 10/16/15 at 3:32 p.m. Resident #18's diagnoses included, but were not limited to, Alzheimer's disease, depression and chronic pain. Resident #18 had a current, 6/17/15, physician's order for a low air loss mattress and a, 6/22/15, order for full side rails times 2 as enabler for mobility and transfer.</p> <p>Resident #18 had a 9/4/15, admission/14 day, Minimum Data Set (MDS) assessment which indicated the resident required assistance to make decisions in new situations only and was totally dependent on staff assistance for bed mobility.</p> <p>Resident #18 had a 9/10/15, care plan problem/need regarding the use of 2 full side rails due to manufacturer's recommendation with low air loss mattress.</p>			

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	<p>Resident #18 had a "side Rail Screen", which was dated as reviewed and updated 8/2/15, which indicated "has 2 side rails manufacture's recommendation due to low air loss mattress."</p> <p>Resident #18 was observed in bed with a low air loss mattress and full side rails up on both sides of the bed on 10/13/15 at 2:25 p.m., 10/14/15 at 1:55 p.m. and 10/16/15 at 4:01 p.m.</p> <p>During a 10/14/16, 10:02 a.m., interview, the Director of Nursing indicated Resident #18 used full side rails with her low air loss mattress due to manufacturer's recommendations.</p> <p>During a 10/16/15, 1:00 p.m., interview, the Director of Nursing indicated Resident #18 used a "Medline-Supra CXC" low air loss mattress.</p> <p>A "Medline-Supra CXC" manual for a low air loss mattress, provided by the Assistant Director of Nursing (ADON) on 10/16/15 at 1:00 p.m., did not contain any recommendation for full side rail use with the air loss mattress. During an interview on 10/16/15 at 1:00 p.m., the ADON indicated the manufacturer did not make a recommendation for full side rail use. She additionally indicated Resident #18 was currently using this</p>			

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	<p>style of low loss mattress with full side rail use.</p> <p>A4. Resident #33's clinical record was reviewed on 10/16/15 at 3:33 p.m. Resident #33 diagnoses included, but were not limited to, Alzheimer's disease, glaucoma and hypertension. Resident #33 had a current, 11/12/14, physician's order for a low air loss mattress with full side rails per manufacturer's recommendations.</p> <p>Resident #33 had a 7/25/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, rarely to ever made independent decisions, was totally dependent on staff assistance for bed mobility and had limited range of motion in both the upper and lower extremities.</p> <p>Resident #33 had a, 9/24/15, care plan problem/need regarding the use of 2 full side rails. Approaches to this problem included, but were not limited to, "low air loss mattress- 2 full side rails."</p> <p>During a 10/16/15, 2:30 p.m. interview, the Director of Nursing indicated Resident #33 used a Synergy Air Elite Mattress.</p> <p>During a 10/16/15, 2:10 p.m. interview,</p>			

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	<p>the Director of Nursing indicated 5 of the residents who currently resided in the facility used a low air loss mattress. She indicated Residents #1 and #27 were provided the low air loss mattresses they were using by the hospice provider. She indicated the hospice provider contracted with an equipment provider who delivered and assembled the low air loss mattress. She indicated the equipment service did not provide a manual for each mattress when they were delivered. She indicated Resident #18 and #33 both used a low air loss mattress provided by the facility.</p> <p>During a 10/15/15, 2:35 p.m., interview, the DON indicated she believed the facility at one time had a low air loss mattress that recommended full side rail use and this had in turn became facility process.</p> <p>A "Synergy Air Elite Mattress" manual, provided by the DON on 10/16/15 at 2:30 p.m., did not contain any recommendation for full side rail use with this air loss mattress. During a 10/16/15, 2:43 p.m., interview, the ADON indicated the manufacturer did not make a recommendation for full side rail use. She additionally indicated Resident #33 was currently using this style of low air loss mattress with full</p>			

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	<p>side rail use.</p> <p>B1. The clinical record for Resident #37 was reviewed on 10/16/15 at 1:47 p.m. Diagnoses for Resident #37 included, but were not limited to, diabetes, hypertension, and dementia.</p> <p>A quarterly Minimum Data Assessment Set (MDS), dated 8/7/15, indicated Resident #37 had severe cognitive impairment, and never or rarely made decisions.</p> <p>A health care plan problem, revised 6/18/15, indicated Resident #37 had diabetes. Interventions for this problem included, but were not limited to, observing for signs of hypoglycemia/hyperglycemia, and monitoring blood sugars "as ordered and more frequently as indicated."</p> <p>A "POST FALL INVESTIGATION", dated 8/17/15, time of occurrence 9:00 p.m., indicated Resident #37 was "found on the floor." The investigation form lacked documentation of the resident's diabetic status and the result of blood sugar at time of occurrence.</p> <p>A "POST FALL INVESTIGATION", dated 8/30/15, time of occurrence 2:00 a.m., indicated Resident #37 had been found on his knees. The investigation</p>			

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	<p>form lacked documentation of a blood sugar result at the time of occurrence.</p> <p>A "POST FALL INVESTIGATION", dated 9/3/15, time of occurrence 7:30 p.m., indicated Resident #37 was going to the bathroom and fell. The investigation form indicated the resident was a diabetic but lacked documentation of a blood sugar result at the time of occurrence.</p> <p>Review of the nurses notes, the Medication Administration Records (MAR), and the "BLOOD GLUCOSE MONITORING/SLIDING SCALE INSULIN RECORD" for the dates and times of the occurrences lacked any documentation of blood sugar monitoring and results.</p> <p>B2. The clinical record for Resident #35 was reviewed on 10/15/15 at 2:12 p.m. Diagnoses for Resident #35 included, but were not limited to, diabetes, hypertension, and dementia.</p> <p>A quarterly Minimum Data Assessment Set (MDS), dated 6/7/15, indicated Resident #35 had moderate cognitive impairment, made poor decisions, and required cueing/supervision.</p> <p>A health care plan problem, revised</p>			

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	<p>9/24/15, indicated Resident #35 had diabetes. Interventions for this problem included, but were not limited to, observing for signs of hypoglycemia/hyperglycemia, and monitoring blood sugars "as ordered and more frequently as indicated." Next to the intervention to monitor blood sugars "BID [twice a day]" and discontinued were hand written, with no date. The health care plan indicated Resident #35 had been on a oral diabetic medication previously and had Hemoglobin A1C blood tests (a blood test to monitor blood sugar) ordered for every 3 months.</p> <p>A "POST FALL INVESTIGATION", dated 9/29/15, time of occurrence 11:45 p.m., indicated Resident #35 was "found on the floor." The investigation form indicated the resident was not a diabetic.</p> <p>A "POST FALL INVESTIGATION", dated 10/1/15, time of occurrence 1:00 a.m., indicated Resident #35 was "found on the floor." The investigation form indicated the resident was not a diabetic.</p> <p>A "POST FALL INVESTIGATION", dated 10/7/15, time of occurrence 12:35 a.m., indicated Resident #35 was witnessed transferring self. The investigation form indicated the resident was not a diabetic.</p>			

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	<p>Review of the nurses notes, the Medication Administration Records (MAR), and the "BLOOD GLUCOSE MONITORING/SLIDING SCALE INSULIN RECORD" for the dates and times of the occurrences lacked any documentation of blood sugar monitoring and results.</p> <p>During an interview on 10/19/15 at 2:30 p.m., LPN #2 indicated after a fall or occurrence involving a diabetic resident the resident's blood sugar was to be obtained. During an interview on 10/19/15 at 3:46 p.m., LPN #2 indicated the nurse completed the post fall investigation form and the accident/incident investigation form. She indicated she could not think of any other place the nurse would document the blood sugar other than the fall/accident forms, the nurses notes, the MAR, or the blood glucose monitoring record.</p> <p>During an interview on 10/19/15 at 2:31 p.m., LPN #3 indicated if a resident was diabetic and fell or had an accident the resident's blood sugar was to be checked.</p> <p>During an interview on 10/19/15 at 4:33 p.m., the Director of Nursing (DON) indicated a diabetic resident should have their blood sugar checked at the time of a</p>			

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F 0356 SS=C Bldg. 00	<p>fall/occurrence. She indicated she did not think Resident #35 was a diabetic since he was not receiving medication for diabetes or having his blood sugar monitored.</p> <p>Review of the current policy, dated 10/2014, titled "FALL PREVENTION PROGRAM", provided by the DON on 10/19/15 at 4:43 p.m., included, but was not limited to, the following:</p> <p>"...Should a resident incur a fall, the licensed personnel will complete an Accident/Incident Report AND POST FALL INVESTIGATION in an effort to identify potential causal factors and prevent a recurrent fall...."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> </ul> </li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2015
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	<p>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>- Certified nurse aides.</p> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <p>o Clear and readable format.</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the list of "nursing staff on duty" was posted and updated on a daily basis as required. This had the potential to effect 44 of 44 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the initial tour on 10/13/15 at 9:30 a.m., the daily "Nursing Staffing" posting was not observed. During additional observations on 10/13/15 at 2:45 p.m., 10/14/15 at 8:30 a.m. and 2:30 p.m., 10/15/15 at 9:37 a.m. and 1:30</p>	F 0356	<p>1 No residents were harmed due to this alleged deficient practice. The daily nursing staffing hours are posted daily. The daily nursing staffing hours posting has been re-designated to a prominent location in the front lobby, in a plexiglass frame. 2. All residents have the potential to be effected by this deficient practice. See below for corrective actions. 3. The facility's policy for posting of nursing staff hours has been reviewed and no changes are indicated at this time (See Attachment). The nurses have been re-educated on the policy with a special focus on posting it</p>	11/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155549	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2015
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	<p>p.m., 10/16/15 at 8:16 a.m., and on 10/19/15 at 8:35 a.m. and 5:00 p.m., the daily "Nursing Staffing" posting was not observed.</p> <p>During an observation with the Corporate Regional Regulatory Auditor on 10/19/15 at 5:01 p.m., the "Nursing Staffing" posting was not observed.</p> <p>During an interview with RN Consultant on 10/19/15 at 5:03 p.m., she indicated the "Nursing Staffing" posting was not posted. She indicated it should have been posted on the "Thank You" bulletin board adjacent to the lobby.</p> <p>During an interview with the Assistant Director of Nursing on 10/19/15 at 5:04 p.m., she indicated the third shift nurse was responsible for posting the daily "Nursing Staffing" and the Director of Nursing and the Assistant Director of Nursing checked it to ensure it was correct.</p> <p>The Assistant Director of Nursing provided the "Nursing Staffing" on 10/19/15 at 5:06 p.m. She indicated it had been posted by the mirror on the wall across from Wing 1's nurse's station. When the mirror was observed there was no posting nor indication of a sign having been displayed in the past. The Assistant</p>		<p>daily (See Attachment). A Posting Audit form has been implemented (See Attachment). 4. The Administrator or designee will be responsible for completing the Posting Audit on scheduled work days as follows: daily on scheduled work days on an ongoing basis for a minimum of 6 months. Should a concern be noted, immediate corrective action will occur. Results of these reviews, concerns, and any corrective actions will be reviewed during the facility's QA meetings and the plan adjusted accordingly.</p>	

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F 0371 SS=E	<p>Director of Nursing could not identify where or how the posting was displayed by the mirror. She indicated she did not know where the posting she provided had come from.</p> <p>Review of the current facility policy, dated 10/2014, titled "POSTING OF DAILY NURSING STAFFING HOURS", provided by the Corporate Regional Regulatory Auditor on 10/19/15 at 5:18 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure that personnel and visitors have access to the actual number of hours worked by licensed and non-licensed personnel daily.</p> <p>POLICY: Facility personnel will ensure daily posting of the total numbers of actual hours worked by licensed and non-licensed nursing personnel directly responsible for resident care per shift....The form will be posted in a designated area that is prominent and readily accessible to residents and visitors...."</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE,</p>				

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Bldg. 00	<p><b>STORE/PREPARE/SERVE - SANITARY</b></p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to prepare and store food under safe sanitary conditions regarding the cleanliness of equipment, the labeling and/or dating of food in the freezer and the refrigerator.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 10/13/15 at 9:25 a.m., the dry storage area had crumbs on the floor under the shelving. The coffee pot area had crumbs and dirt behind the coffee pot. The stove and steam table knobs had a visible build up of dirt. The freezer contained 2 opened food items not labeled or dated. The Dietary Manager indicated one of the opened items was bologna which was wrapped in foil. The other opened item was french toast wrapped in foil with no date or label. The 2 of 2 tray racks had dirt and debris build up on the wheels, and the racks had dried food on the tray slots. The silver range hood over the stove had debris and black places where paint was missing. The personal protection equipment used to clean the</p>	F 0371	<p>1.No residents were harmed. The dry storage area has been cleaned and the floor replaced. The coffee pot area has also been cleaned along with the stove and steam table knobs. The staff was educated on labeling and dating of items in the freezer, storage of non food items, and educated about the importance of cleaning schedules. The tray racks and their wheels were cleaned, the hood painted, and the personal protection equipment was placed on the shelf under the dish machine. The door frame to the dry storage was painted and glue has been removed from the prep area floor.</p> <p>2.All residents have the potential to be affected. See below for corrective measures.</p> <p>3.An in-service was provided to the dietary staff including labeling and dating, storage of non-food items and cleaning (See Attachment). The dietary manager or designee will complete sanitation rounds (See Attachment) daily (Monday through Friday) for 4 weeks and then twice weekly for 4 weeks then weekly for 2 months then monthly to ensure continued compliance indefinitely. Should a</p>	11/18/2015			

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	<p>dishwasher was stored on the floor in a plastic bag.</p> <p>On 10/14/15 at 9:40 a.m., the door frame of the dry storage area was rusty and had dirt build up. The new floor had glue on top of it at the prep area.</p> <p>During an interview with the Dietary Manager on 10/14/15 at 10:36 a.m., she indicated the above areas of concern were on a weekly cleaning schedule. She provided a "Weekly Dietary Aid Cleaning Schedule" and the "Weekly Cook Cleaning Schedule", dated from 9/28/15 through 10/17/15. The schedule indicated the above areas of concern had been cleaned on a weekly basis.</p> <p>On 10/16/15 at 10:55 a.m., the dry storage continued to have crumbs on the floor, the crumbs and dirt remained behind the coffee pot. The stove and steam table knobs continued to have a visible build up of dirt.</p> <p>The policy "Storage of Food under Sanitary Conditions", dated 11/2014, provided by the Dietary Manager on 10/16/15 at 11:55 a.m., included, but was not limited to, leftover foods should be placed in an approved storage container and should be discarded after three days. All food items in the refrigerator must be</p>		<p>concern be found, immediate corrective action will occur.</p> <p>4. The findings of the above audits and any corrective actions will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>				

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F 0465 SS=E Bldg. 00	<p>labeled and dated if not scheduled to be served at the next meal.</p> <p>3.1-21(i)(1) 3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure resident rooms were clean, in good repair, and odor free for 10 of 27 rooms observed for cleanliness and a homelike environment. This deficient practice affected 15 of the 15 residents residing in the 10 rooms observed. (Room #'s 106, 108, 109, 110, 118, 119, 120, 121, 122, and 123)</p> <p>Findings include:</p> <p>1. During a resident room observation on 10/13/2015 at 3:30 p.m., Room 110 had deep scratches in the floor with dirt build up, a rusty empty metal toilet paper holder was on the wall on the right side of the toilet.</p>	F 0465	<p>1. No residents were affected by this alleged deficiency. Room 110's floor has been repaired and cleaned. The toilet paper holder has been removed and a new one implemented. Room 109's floor has been repaired and cleaned. The entrance door's threshold has been cleaned. The light cover has been removed and cleaned. The cove base has been reattached and the tape has been removed. The wall to the left of the door has been repaired and is now free from holes. The bathroom being shared by rooms 119 and 120: the discoloration under the stool has been repaired and cleaned. The wall behind the stool has been cleaned. The holes above the paper towel holder have been repaired. Room 120's base board heater's cover has been replaced. The</p>	11/18/2015

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	<p>2. During a resident room observation on 10/14/15 at 10:19 a.m., Room 109 had deep scratches in the room's floor with dirt build up. The threshold at the entrance door had dirt build up. The light cover in the room had multiple dead insects in it. The cove base had separated from the wall and was repaired with tape above the heater unit. The wall to the left of the door had holes in the plaster.</p> <p>3. During a resident room observation on 10/14/2015 at 12:48 p.m., the bathroom, shared by Room 119 and 120, had a discoloration under the stool. A green brown substance was on the wall behind the stool. There were two holes in the plaster above the paper towel holder.</p> <p>4. During a resident room observation on 10/15/2015 at 8:37 a.m., Room 120's base board heater was missing the front cover. The wall above the cabinets in the room was not painted to match the rest of room.</p> <p>5. During a resident room observation on 10/14/15 at 1:57 p.m., Room 118's bathroom had a discoloration under the stool. The wall by the sink was rough with patched drywall. The baseboard heater was missing it's cover.</p>		<p>walls have been repainted and the colors match. Room 118's bathroom: The discoloration under the stool has been repaired and cleaned. The wall by the sink has been repaired. The baseboard heater's cover has been replaced. Room 108's room &amp; bathroom: There is no longer a musty smell in the bathroom. The tile behind the toilet has been repaired and cleaned. The wallpaper has been repaired and the tape removed. The shared bathroom between rooms 121 &amp; 122: The wall behind the stool has been repaired. The discoloration under the stool has been repaired and cleaned. Room 106: The wallpaper has been repaired. The floor has been cleaned. The bathroom threshold has been repaired. Room 123: A threshold strip at the room entrance has been placed. The discoloration under the stool in the bathroom and been repaired and cleaned. The walls next to the entrance door and behind the bed have been repaired and painted. 2. All residents have the potential to be affected. See corrective actions below. 3. The Maintenance Supervisor has been re-educated on the facility's preventative maintenance program with a special focus on providing a facility that is clean, in good repair, and free from odors (See Attachment). A rounding audit tool has been implemented</p>		

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	<p>6. During a resident room observation on 10/14/15 at 1:01 p.m., Room 108's bathroom had a musty odor. During a 10/15/15 at 9:54 a.m., resident room observation, the wall paper was taped to the wall and had separated under the window. The bathroom had a musty odor, and the tile behind the toilet was stained dark.</p> <p>7. During a resident room observation on 10/14/15 at 4:16 p.m., the shared bathroom between rooms 121 and 122 had white unfinished plaster on the wall behind the stool and discoloration under the stool.</p> <p>8. During a resident room observation on 10/15/15 at 9:34 a.m., Room 106's wall paper was curling off the wall by the window heating unit. The floor had dirt build up in the corners. The bathroom threshold had a section of wood missing.</p> <p>9. During a resident room observation on 10/15/15 at 7:40 a.m., Room 123 was missing a threshold strip at the entrance of the room. There was discoloration under the stool in the bathroom. The walls next to the entrance door and behind the bed had areas of white unfinished plaster.</p> <p>During the environmental tour on</p>		(See Attachment). 4. The Administrator or designee will be responsible for completing the rounding audit tool on a weekly basis to ensure the facility is clean, in good repair, and odor free. Should a problem be found, immediate corrective action will occur. Result of these reviews and any corrective actions will be reviewed during the facility's QA meetings and the plan adjusted if indicated.				

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F 9999  Bldg. 00	<p>10/16/15 at 10:30 a.m., the Maintenance Supervisor indicated he completed room inspections of the resident rooms once a month. He indicated he was behind in his inspections because he had been laying a new floor in the kitchen.</p> <p>The policy titled "Preventative Maintenance Program", undated, indicated each resident room should be inspected for potentially needed repairs on a quarterly basis, and the maintenance personnel should complete the "Resident Room Inspection Schedule". The resident's bathroom equipment, and the condition of the floors were included in the inspection. The Maintenance Supervisor provided a "Resident Room Safety Report" on 10/16/15 at 3:27 p.m. He indicated the report was used as the inspection check off. This report included, but was not limited to, damaged walls, baseboards, door trim, sharp edges, door frames, and carpet thresholds.</p> <p>3.1-19(f)</p> <p>STATE RULE:</p>	F 9999	1.No residents were harmed	11/18/2015

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	<p>3.1-14 Personnel</p> <p>(s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 1 of 18 CNA's working had a current CNA certificate. This deficient practice had the potential to affect 44 of 44 residents residing in the facility. (CNA # 1)</p> <p>Findings include:</p> <p>The employee record review was completed on 10/19/15 at 4:22 p.m. 18 of 18 CNA records were reviewed for certification, since there were 18 CNAs on the schedule to work during the survey. The records indicated CNA #1's Nurse Aide Certification had expired on 1/13/15.</p> <p>CNA #1's work schedule, dated 10/4/15 through 10/17/15 provided by the Director of Nursing on 10/19/15 at 9:30 a.m., indicated CNA #1 worked 6 days from 10/4/15 to 10/17/15.</p> <p>During an interview on 10/19/15 at 4:30</p>		<p>due to this alleged deficient practice. The license and certification binder has been updated and all licenses and certifications are in active status.</p> <p>2.All residents had the potential to be affected by this deficient practice. See corrective action below.</p> <p>3.The office manager has been educated as to updating the license and certification binder and keeping it organized (See Attachment). A license audit form has been implemented (See Attachment).</p> <p>4.The Administrator or their designee will audit the license and certification binder each month to ensure all licenses remain current and active. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated</p>	

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	<p>p.m., the Director of Nursing indicated she became aware of CNA #1's expired certification on 10/19/15 and removed CNA #1 from the schedule. The Director of Nursing provided documentation of a Nurse Aide Registry CNA Renewal.</p> <p>During an interview on 10/19/15 at 4:30 p.m., the Director of Nursing indicated the infection control nurse or herself were responsible for ensuring all licenses and certificates were current.</p>				