

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/30/2015
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NAME OF PROVIDER OR SUPPLIER  WATERS OF COVINGTON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
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F 000  Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>This visit included Investigation of Complaint IN00166151.</p> <p>Complaint IN00166151-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 22-26, 2015 and March 30, 2015.</p> <p>Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 16 Medicaid: 57 Other: 18 Total: 91</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies, or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests a desk review cerification of complaince on or after 04-29-2015. Fay Pruitt, HFA	

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 242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure residents' preferences for wake time and/or frequency of bathing/showers were honored for 3 of 3 residents reviewed for choices. (Resident #44, #91 and #105)</p> <p>Findings include:</p> <p>1. During an interview of Resident #105, on 3/23/15 at 10:35 a.m., the resident indicated staff woke him between 4:30 a.m. and 5:00 a.m. and indicated he was scheduled for showers twice a week. Resident #105 indicated he preferred sleeping later and wanted 2-3 showers per week.</p> <p>On 3/25/2015 at 11:36 a.m., CNA #3 indicated Resident #105 scheduled showers were on Tuesday and Friday</p>	F 242	<p><b>F242How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b> These three residents with varying degrees of cognitive decline have since been interviewed, and voiced they have no preference for day, time, type or number of baths weekly.</p> <p>Family and/or interested party have also been interviewed for input on scheduled bath routine.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> All new admissions and current residents will be interviewed for bathing preferences: type of bath, time, day and number of baths/showers weekly utilizing the Bathing Preference Form; with information updated on the pocket work sheet and care plan as indicated. This subject will be</p>	04/29/2015

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	<p>during the 10 p.m. to 6 a.m. shift.</p> <p>On 3/25/15 at 12:20 p.m., Director of Nursing (DON) indicated Resident #105's assigned shower days were on Tuesday and Friday.</p> <p>Resident #105's clinical record was reviewed on 3/25/15 at 10:00 a.m. A quarterly assessment, dated 2/11/15, indicated the resident was moderately cognitive impaired and required one person physical assist for showers.</p> <p>A form titled, "NURSING ASSISTANT POCKET WORKSHEET F.W. LIST 1," was received from the LPN #4 on 3/25/15 at 11:40 a.m. The form indicated Resident #105 received two showers a week on the third shift.</p> <p>2. On 3/23/15 at 11:31 a.m., during the stage 1 interview, Resident #91 indicated he got a shower one time a week. He indicated staff never asked his preference for the number of showers.</p> <p>On 3/25/15 at 2:58 p.m., during an interview, Resident #91 indicated he would like to have at least two showers a week.</p> <p>Resident #91's record was reviewed on 3/26/15 at 10:07 a.m. The Brief Interview of Mental Status (BIMS) score</p>		<p>reviewed and clarified (or changed if indicated) at each care plan conference. Through audit, no other residents were identified. <b>What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur:</b> A new Bathing Preference form was implemented during the survey visit. The activity director will continue to interview new residents and bathing preferences placed on the pocket work sheet and care plan as indicated. Bathing information is documented on the activity admission review and quarterly progress note. Staff in-serviced as to the Resident's Right to choose. If any resident voices a desire to have their bath routine changed the information should be shared with the charge nurse who should include information on the 24 hour report so that the Activity Director can learn of the request at the next daily CQI meeting to ensure resident choice is implemented. Activity Director will interview 5 interview able residents weekly to ensure bath preferences are being honored. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved, and then random monthly interviews will be done by the Activity Director. Any concerns will be addressed as they are reported. <b>How the facility will monitor its corrective actions</b></p>	

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	<p>on the quarterly Minimum Data Set (MDS), dated 12/15/14, indicated the resident had no cognitive impairment.</p> <p>A quarterly care plan, dated 3/23/15, indicated the resident the resident required assist with ADLs (activities of daily living) due to weakness and limited mobility.</p> <p>3. On 3/23/15 at 10:23 a.m., Resident #44 was interviewed. The resident indicated she was not asked how often she preferred a shower or bath but was told she would be showered on Tuesdays and Fridays.</p> <p>The resident's clinical record was reviewed on 3/26/15. A quarterly Minimum Data Set assessment (MDS) dated, 1/22/15, coded the resident with no cognitive impairments. The Annual MDS assessment dated, 10/25/14 coded it was somewhat important for the resident to choose between types of baths.</p> <p>On 3/25/15 at 11:52 a.m. the Activity Director was interviewed. The director indicated she was responsible for completing the preferences for customary routines section of the assessment. The director indicated she did not ask what was the residents' preference regarding frequency of showers.</p>		<p><b>to ensure that the deficient practice is being corrected and will not recur:</b> Activity director will review resident preferences quarterly and with MDS schedule and also as received in the daily CQI meetings. Preferences will be honored as they become known to the staff. Any patterns of concerns with preferences not being honored which are discovered through the interview monitoring process will be addressed/corrected as known and will be reviewed during monthly QA meeting. This change will be performed in an ongoing manner. Administrator to monitor. <b>By what date the systemic changes will be completed:</b> April 29, 2015</p>				

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F 323 SS=D Bldg. 00	<p>A current facility policy titled, "Resident Rights, " was provided on 3/30/15 at 11:30 a.m., by the Director of Nursing. The policy indicated the residents had the right to "...Receive care in a manner which promotes and enhances your quality of life...to meet your needs and preferences..."</p> <p>3.1-3(u)(1)(3)</p> <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 a safe environment for 1 of 35 residents reviewed in stage 1 in that an electrical cord was draped across the wall and within reach of the resident. (Resident #1)</p> <p>Finding includes:</p>	F 323	<p><b>F323 How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b> The electrical cord coming from the over the bed light is run down to the electrical outlet for resident lighting. As the light cord cannot be moved, the cord will be covered with a Non-metallic raceway to prevent the resident from being able to</p>	04/29/2015
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	<p>On 3/24/15 at 11:20 a.m. Resident #1 was observed in a low bed, with one side of the bed against the wall. A heavy, black, electrical cord was draped across the wall from a wall mounted light fixture, to an electrical outlet behind the resident's bed. The resident's call light was attached to the electric cord.</p> <p>Resident #1's clinical record was reviewed on 3/24/15 at 11:45 a.m. The annual Minimum Data Set (MDS) assessment, dated 12/5/14 coded the resident with moderate cognitive impairment unable to conduct interview. The assessment coded the resident required assistance for mobility and positioning, utilized a walker, had no range of motion limitations and diagnoses that included, but were not limited to dementia and psychotic disorder.</p> <p>During the environmental tour with the Maintenance Supervisor which began at 11:15 a.m. on 3/30/15, the Supervisor indicated the call light was not hardwired into the wall and would be upgraded.</p> <p>3.1-45(a)(1)</p>		<p>grasp the cord or the resident's light cord from being attached to it. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> The Maintenance Director will audit all resident rooms for draped electrical cords having the potential to be within residents reach. Through audit, no other residents were identified. <b>What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur:</b> All staff immediately in-serviced as to the need to immediately report to the maintenance staff any loose or dangling or unsecured cord which could be accessible to a resident or which could cause a trip hazard. The Maintenance Director and/or administrator will make facility wide rounds 3 days weekly X 4 weeks to ensure that no such cords are present. The Maintenance Director will monitor for draped cords during monthly rounds with the results monitored on the Monthly Preventative Maintenance Log and reported during Quarterly QA. <b>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</b> The Maintenance Director shall report to QA Committee. The QA Committee to provide suggestions as needed. This change will be performed in an</p>		

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F 371 SS=F Bldg. 00	<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, interview, and record review, the facility failed to ensure dietary staff adequately washed hands when entering the kitchen and before preparing food. This deficient practice had the potential to affect 91 of 91 residents served who received food prepared in kitchen.</p> <p>On 3/26/15 at 10:10 a.m., upon entering the kitchen, the Dietary Director was observed washing her hands at the kitchen hand washing sink. The Dietary Director turned on the faucet, wet her hands with water, applied soap to her hands, scrubbed hands with the soap for less than five seconds, rinsed hands, dried her hands with a paper towel and turned off the faucet with the paper towel.</p> <p>On 3/26/15 at 10:15 a.m., Cook #5 was observed washing her hands at the kitchen hand washing sink. Cook #5</p>	F 371	<p>ongoing manner. Administrator to monitor. <b>By what date the systemic changes will be completed:</b> April 29, 2015</p> <p><b>F371 How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b> No specific residents were identified as being affected during survey. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> Residents who receive food/beverages prepared in the dietary kitchen have the potential to be affected by this finding. <b>What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur:</b> Dietary employee's re-in-serviced on Policy and Procedure for hand washing and safe handling of food during meal prep. Clock installed just above the hand sink to be used to time handwashing. Dietary Manager will observe hand washing for 2 dietary staff 3 days weekly. The staff members will be observed to</p>	04/29/2015

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	<p>turned on the faucet, wet her hands with water, applied soap to her hands, scrubbed hands with the soap for less than five seconds, rinsed hands, dried her hands with a paper towel and turned off the faucet with the paper towel. Cook #5 then proceeded to puree meat.</p> <p>On 3/26/15 at 10:50 a.m., the Dietary Director indicated staff are instructed to wash hands upon entering the kitchen, after completion of a task and before moving to a clean area. The Dietary Director indicated staff are instructed when handwashing to scrub 15 to 20 seconds or more with soap prior to rinsing with water.</p> <p>On 3/26/15 at 11:00 a.m., the Dietary Director provided a current policy and procedure for hand washing, titled, "Glove and Hand Washing Procedures." The document included, but was not limited to: "...All employees will use proper hand washing procedures and glove usage in accordance with State and Federal Sanitation Guidelines...PROCEDURE...Wet hands and apply soap. Scrub 15-20 seconds or more...Lather all areas of hands and wrists, rubbing vigorously for at least</p>		<p>see that all points of the policy and procedure on hand washing are demonstrated. These observations will be documented and will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, random weekly observations will occur ongoing. Any concerns will be addressed/corrected as observed. Any staff who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate. <b>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</b> Dietary Director will randomly monitor for compliance through weekly audits and document on the auditing tool. Audit results will be reported to QA Committee for discussion. However, any concerns will have been addressed as discovered. QA Committee to offer suggestions as necessary. <b>By what date the systemic changes will be completed:</b> April 29, 2015</p>	

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F 441 SS=D Bldg. 00	<p>20-30 seconds: getting under nails, between fingers, and all exposed areas, such as back of hands and forearms...Turn off faucet with clean paper towel...."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin</p>			

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	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to maintain a breathing treatment device in a sanitary manner for 1 of 1 random observation of a resident receiving a nebulizer treatment. (Resident #91)</p> <p>Finding includes:</p> <p>On 3/30/15 at 10:02 a.m., Resident #91 was observed to receive a nebulizer treatment. The nebulizer mask was stored in a plastic bucket that also contained a cell phone power cord on the resident's bedside table. The mask was observed with a whitish substance on the interior. An electric razor was placed in a stand with a heavy accumulation of whiskers and was stored next to the bucket containing the nebulizer mask.</p> <p>Resident #91's clinical record was reviewed on 3/30/15 at 4:00 p.m. A physician's telephone order was noted</p>	F 441	<p>F441 <b>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident had no negative reaction and was reminded to leave his nebulizer mask bagged versus storing with his personal effects. Resident #91 has his nebulizer mask stored in the appropriate, clean container (bag per policy) <b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> No other residents were identified during survey. An audit was conducted facility wide at which time no residents who use a nebulizer mask were found to have their mask stored improperly. Through audit, no other residents were identified. <b>What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur:</b> DON/Designee will monitor 3 days weekly to ensure that all residents who use a nebulizer</p>	04/29/2015

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F 456 SS=D Bldg. 00	<p>dated 3/16/15 for a Duoneb treatment two times daily and as needed.</p> <p>An order on the March 2015 signed recapitulation of physician's orders included, but was not limited to, change oxygen equipment every Friday when in use.</p> <p>A facility policy titled "Nebulizer Therapy," issued 2/28/12, and provided as current by the Assistant Director of Nursing on 3/30/15 at 4:00 p.m. included, but was not limited to, ..."Procedure: 13. Store nebulizer and mouthpiece/mask in plastic bag, after appropriate cleaning per policy."...</p> <p>3.1-18-(1)</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, interview, and record review, the facility failed to</p>	F 456	<p>mask have their masks stored properly between uses and that the masks are clean. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, weekly monitoring will occur on going. Random audits on each unit to be conducted on a declining basis starting with daily x 1 week, 3 times weekly x 1week , then randomly per the DON or designee. . All nurses re-in-serviced on Nebulizer Policy and Procedure to include cleaning and storage of equipment. Any nursing staff who fails to comply with the points of the in-servicing will be further educated and/or progressively disciplined as appropriate. <b>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</b> Monitoring results will be reviewed in the monthly QA meetings to identify any patterns. However, any discrepancies with the policy will have been addressed as found. <b>By what date the systemic changes will be completed:</b> April 29, 2015</p> <p><b>F456 How corrective action will be accomplished for those</b></p>	04/29/2015	

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	<p>maintain resident equipment in a functional manner for 1 of 35 residents reviewed in the stage I sample in that an adaptive device placed on Resident #77's wheelchair interfered with the mobility of the chair.</p> <p>Finding includes:</p> <p>On 3/23/15 at 11:25 a.m., Resident #77 was interviewed. The resident indicated she utilized a wheelchair provided by the facility for mobility. The resident indicated something drug on the wheels of the chair and indicated it was hard to maneuver.</p> <p>On 3/30/15, during an environmental tour with the Maintenance Supervisor which began at 11:15 a.m., the wheelchair was observed to have anti-roll back brakes that drug on both wheels. The Supervisor indicated the physical/occupational therapy department was also responsible for checking residents' devices. The resident reported to the Maintenance Supervisor during the tour that she had reported to therapy that the chair would not roll. The Maintenance Supervisor indicated he had not received a work order to repair the wheelchair.</p> <p>Resident #77's clinical record was reviewed on 3/23/15 at 11:45 a.m. The</p>		<p><b>residents found to have been affected by the deficient practice:</b> This resident with progressive Parkinson's disease has difficulty at times with propelling herself and is currently utilizing a new w/c provided by and specifically adjusted for her per the Therapy Department. Maintenance Director adjusted the anti-rollbacks on her chair immediately when reported during the survey process. All wheelchairs with anti-rollbacks throughout the facility were checked by the maintenance staff to ensure they were in good working order. Interviewable residents who use wheelchairs with anti-rollbacks were interviewed by the DON/Designee as to any functional concerns they might have with their wheelchair. Any findings were corrected.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> Work orders will be submitted to maintenance department. <b>What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur:</b> Staff and therapy personnel re-in-serviced on Maintenance Work Orders. Any staff who fails to comply with the points of the in-servicing will be further educated and/or progressively disciplined as appropriate. The Maintenance Director will monitor w/c with</p>		

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F 465 SS=E Bldg. 00	<p>Annual Minimum Data Set (MDS) assessment, dated 11/19/14 indicated the resident was without cognitive impairment. The assessment indicated the resident required limited assistance with locomotion on the unit.</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 and interview the facility failed to ensure a comfortable and safe environment for 1 of 3 units (intermediate skilled hallways).</p> <p>Findings include:</p> <p>During the environmental tour with the Maintenance Director on 3/30/15 beginning at 11:15 a.m., the following issues were observed on the intermediate unit:</p>	F 465	<p>anti-rollback devices during monthly rounds and will correct any concerns as they are found. This will be ongoing, with the results monitored on the Monthly Preventative Maintenance Log and reported during Quarterly QA. <b>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</b> The Maintenance Director shall report to QA Committee. The QA Committee to provide suggestions as needed. Administrator to monitor. <b>By what date the systemic changes will be completed:</b> April 29, 2015</p> <p>F465 <b>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b> The nurses' station is free of odors. Rm 17-B lower inner bathroom door and wall with light fixture have been repaired. Rm 21-B wall above the bed has been repaired. Rm 18-B gouges in bathroom door and frame and tape on top of grab bar have been repaired. Rm 14-B rust at base and interior of toilet/toilet bowl and dust along base of walls and in corners has been repaired. Rm</p>	04/29/2015

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	<p>a. An odor was noted at the nurse's station..</p> <p>b. In room #17-B, the lower inner bathroom door and frame had several deep gouges and the wall that had a fluorescent light mounted had several scratches and dents.</p> <p>c. In room # 21-B, the wall above the head of the bed had several torn or missing pieces of wall paper.</p> <p>d. In room #18-B, lower inner bathroom door and frame have several deep gouges and the top of the vertical grab bar, next to the toilet was covered with a white tape.</p> <p>e. In room #14-B, a rusty ring around the base of the toilet, heavy rust stains were observed on the interior surface of the toilet bowl and a heavy accumulation of dust was built up along the base of the walls and corners.</p> <p>f. In room #12-B, a heavily marred interior of bathroom door was observed.</p> <p>g. In room #11-A, a heavily marred wall in the bathroom and food and dried spillage was on the floor throughout the room.</p>		<p>12-B marred interior of bathroom door have been repaired. Rm 11-A Heavily marred bathroom door and food spillage on floor throughout room have been repaired. No specific residents were identified as being effected during the survey. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> All resident rooms were toured by the Administrator with the Maintenance director and housekeeping supervisor. A list of environmental findings was compiled. The Administrator, Maintenance Director and Housekeeping Supervisor will meet weekly to discuss progress made. This will be documented. Administrator will make weekly rounds to assess the progress that is being made and add any new issues. The weekly rounds will be ongoing. <b>What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur:</b> The Housekeeping staff was in-serviced on expectations of proper cleaning, cleaning schedules and floor care. The Maintenance staff was in-serviced on expectations of the physical plant environment and the need for timely repairs. Any staff who fails to comply with the points of the in-service will be further educated and/or</p>	

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	<p>During an interview on 3/30/15 conducted during the environmental tour beginning at 11:15 a.m., the Maintenance Director indicated he was responsible for maintaining the facility in good repair and indicated he was aware of repairs needed in resident rooms 17-B, 21-B, 18-B, 14-B, 12-B and 11-A.</p> <p>3.1-19(f)</p>		<p>progressively disciplined as appropriate. On-going Housekeeping in-services on expectations of proper cleaning of facility. Updating of aesthetics of environment on-going, specified rooms repaired. <b>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</b> Housekeeping Supervisor and Maintenance Supervisor to monitor and report to QA Committee. QA Committee to offer suggestions as necessary. This change will be performed in an ongoing manner. Administrator to monitor. <b>By what date the systemic changes will be completed:</b> April 29, 2015</p>		