

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155322	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/19/2016
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NAME OF PROVIDER OR SUPPLIER  RENAISSANCE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation so Complaint IN00206677</p> <p>Complaint IN00206677 Unsubstantiated.</p> <p>Survey dates: August 14, 15, 16, 16, 18, &amp; 19, 2016</p> <p>Facility number: 000215 Provider number: 155322 AIM number: 100267600</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 7 Medicaid: 41 Other: 26 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on August 23, 2016 by 17934.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in</p>			

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	<p><b>assessment.</b></p> <p>Based on observation, interviews and record review, the facility failed to complete a significant change comprehensive assessment addressing end of life care and hospice services for 1 of 1 residents reviewed for hospice services (Resident #82)</p> <p>Findings include:</p> <p>On 8/17/16 at 10:07 A.M., the record for Resident #82 was reviewed. Diagnoses included, but were not limited to, dementia, diabetes mellitus, hypothyroidism, weight loss, and frequents falls. A physician's order dated 6/15/16 indicated hospice services to begin as of this date for Resident #82. A significant change MDS was not found in the record.</p> <p>On 8/19/16 at 10:35 A.M., the MDS nurse was interviewed. During the interview, the MDS nurse indicated she was new to the facility. Further, the MDS nurse indicated the facility was behind in MDS assessments and that a Significant change MDS assessment had not been completed for Resident #82 upon initiation of hospice services and change in condition on 6/15/16.</p> <p>3.1-31(a)</p>	F 0272	<p>Corrective Action for Affected Residents: The Assessment Reference Date (ARD) for the significant change assessment for Resident #82 who admitted into hospice on 6/15/16 was on the MDS Calendar for 6/25/16, but not set in the computer system. On 7/20/16, the significant change assessment was set in the computer system with an adjusted ARD of 8/2/16 and in process. The Significant Change assessment for Resident #82 was finalized on 9/1/16.</p> <p>Corrective Action for Potentially Affected Residents: A full audit was completed on 7/20/16 by the MDS Nurse to identify any outstanding ARDs that had not been set in the computer. On 7/20/16, all affected ARDs were adjusted and set in the system. All MDS assessments with adjusted ARDs will be completed and finalized by 09/16/16.</p> <p>Measures for Prevention: The MDS Nurse was In-Serviced on setting Assessment Reference Dates (ARD) timely for all MDS assessments, to include, significant changes, per the RAI guidelines. QA for Prevention: The MDS Nurse along with the interdisciplinary team will review the MDS calendar on a weekly, and as needed, basis to ensure ARDs have been set in the system in the specified time frame with oversight from the Director of Nursing and</p>	09/16/2016			

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to invite to care plan meetings for 1 of 3 residents reviewed for</p>	F 0280	<p>Administrator. The MDS calendar will be reviewed monthly by the Quality Assurance Committee to ensure compliance that Assessment Reference Dates are set in the system per the RAI guidelines.</p> <p><u>Corrective Action for Affected Residents:</u> Resident#59 and Resident #66 were invited by the SSD to attend the health care</p>	09/16/2016	

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	<p>for care plan meeting invitations (Resident #66). Further, the facility failed to schedule and conduct a care plan meeting for 1 of 4 resident's reviewed for care plan meetings (Resident #59).</p> <p>Findings include:</p> <p>1. On 8/15/16 at 3:01 P.M., Resident #59 was interviewed. During the interview, Resident #59 indicated that she had not been invited to a care plan meeting or involved in developing her plan of care.</p> <p>On 8/18/16 at 10:59 A.M., the Social Service Director (SSD) was interviewed. During the interview, the SSD indicated she sends invitations, via mail, about care plan meetings to families/POA's (power of attorney) and verbally tells residents when their care plan meeting is scheduled. Upon review of the record by the SSD, she indicated that a care plan meeting had not been scheduled and conducted for Resident #59. SSD indicated that Resident #59 had not been invited to her care plan meeting because no care plan meeting had ever been scheduled.</p> <p>On 8/18/16 at 2:02 P.M., during an interview with the SSD, she indicated care plan meetings are conducted following admission to the facility,</p>		<p>plan meeting and discuss their plan of care with the Interdisciplinary Team. POA's were also notified and invited by the SSD to attend the health care plan for Resident #59 and Resident #66. <u>Corrective Action for Potentially Affected Residents:</u> An Audit was completed by the SSD to identify any resident(s) who had not been invited to participate in their health care plan meeting. Any affected residents and the resident's POA, were notified by the SSD, and invited to attend the resident's upcoming health care plan meeting. <u>Measures for Prevention:</u>The facility's policy on Resident Rights-Health Care Plans was reviewed, and revisions to the facility's Health Care Plans policy were completed. The SSD and Interdisciplinary Team will be in-serviced on the facility's revised Health Care Plans policy by 09/07/16. <u>QA for Prevention:</u> The SSD will be responsible for ensuring all residents are invited to their respective health care plans per the facility policy with oversight from the Administrator and Interdisciplinary Team. Health Care Plan implementation and monitoring will be reviewed monthly by the facility's Quality Assurance Committee to ensure compliance that residents have been invited to their health care plan meetings per facility policy.</p>				

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F 0282 SS=D Bldg. 00	<p>quarterly, annually, and with a significant change in resident's condition.</p> <p>2. On 8/15/16, at 3:15 P.M., Resident #66 indicated no invitations had been received for care plan meetings.</p> <p>An interview with the SSD on 8/17/16 at 11:48 A.M. indicated care plan invitations had been sent via mail to Resident #66's family member/Power of Attorney (POA) for meetings for 4/11/16 and 7/20/16. The SSD indicated Resident #66's POA had not attended either care plan meetings and neither had the resident. The SSD indicated the mailed invitations sent to the POA of Resident #66 included an invitation for the resident to attend, but the resident had never been given an invitation in person.</p> <p>Review of a current policy provided by the SSD on 8/17/16 at 2:30 P.M., titled Resident Rights-Health Care Plans, dated 2/11, indicated: "It is the policy of Renaissance Village that all residents and their responsible parties be invited to their Health Care Plan Meeting."</p> <p>3.1-3(n)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>				

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a resident received the correct medication that had been discontinued. This deficiency affected 1 of 1 resident who received a medication that had been discontinued in a sample of 11 residents observed during Medication Administration (Resident #68).</p> <p>Findings include:</p> <p>On 8/14/16 at 7:20 P.M. during medication administration, RN #9 was observed checking Resident #68's Medication Administration Record (MAR) dated 8/14/16 and compared the resident's medications with Resident #68's August 2016 MAR. RN #9 poured the medications tremolo 25 mg(milligrams), risperdal 0.125 mg, and Trazodone 50 mg. RN #9 identified Resident #68 and administered the resident's medications atenolol, risperdal, and Trazodone.</p> <p>On 8/15/16 at 11:30 P.M. Resident #68's clinical record was reviewed and indicated diagnoses of, but not limited to, major depression with psychotic features, and bipolar disorder.</p>	F 0282	<p><u>Corrective Action for Affected Residents:</u> Resident #68 physician's order for Risperdol 0.125mg was discontinued on the MAR on 8/15/16 per the physician's order to discontinue Resident #68 Risperdol 0.125 mg on 08/10/16. Resident #68 physician and POA were notified. No adverse effects were noted to Resident #68. <u>Corrective Action for Potentially Affected Residents:</u> An audit of all Residents' physician's orders was completed by the Unit Managers by 8/31/16 to identify any other affected residents' physician's orders. Any affected physician's orders were corrected at that time and/or further clarification was received from the resident's physician. <u>Measures for Prevention:</u> All Licensed Nursing personnel responsible for medication administration will be in-serviced on the facility's Medication Administration Policy per Physician's Orders. The Unit Managers will monitor for compliance on a daily basis and during change over at the beginning of the each month. <u>QA for Prevention:</u> The facility's Licensed Nursing personnel will be responsible for ensuring medication is administered per the facility's Medication Administration Policy per</p>	09/16/2016	

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	<p>A Physician's order dated 8/10/16 indicated the medication risperdal 0.125 mg had been discontinued. LPN #8 was observed to review Resident # 68's Physician's Order dated 8/10/16 and the August 2016 MAR .</p> <p>In an interview on 8/17/16 at 9:55 A.M. the Director of Nursing Service (DNS) indicated Resident #68's risperdal should have been discontinued on 8/10/16 by the second shift LPN #5 who had received the new order but had not transcribed the new order from the Nurse Practitioner on 8/10/16 to discontinue the medication risperdal. The DNS indicated the third shift LPN # 6 should have checked Resident #68's new orders to discontinue the medication risperdal. The DNS further indicated the first shift LPN #7 should have also checked the new order to discontinue the risperdal for Resident #68.</p> <p>Resident #68's August 2016 MAR indicated Resident #68's risperdal 0.125 mg was signed as given from 8/10/16 through 8/14/16.</p> <p>The DNS on 8/17/15 at 10:45 A.M. provided the current policy for checking Physician's Orders revised on November 24, 2015 which indicated "B. The</p>		Physician's Orders and will be reviewed on a daily basis with oversight from the Unit Managers and Director of Nursing. Any trends will be reviewed, monitored, and analyzed monthly by the facility's Quality Assurance Committee to ensure compliance of the facility's Medication Administration Policy.	

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F 0441 SS=D Bldg. 00	<p>professional nurse taking the order is responsible for checking the order for accuracy, transcribing the order to the appropriate administration record,...and communicating the order to the next shift's nurse." "D. The professional nurse on the next two shifts is to check the order for accuracy, transcription, and completion...." "When the order has been checked, by nurse is to put her initials in the top left corner of the order sheet.</p> <p>3.1-35(g)(2)</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>			

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin 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. Based on observations, interviews, and record reviews, the facility failed to ensure a resident's indwelling urinary catheter bag and tubing were off the floor, and failed to ensure indwelling urinary catheter care was done correctly regarding staff handwashing: after gloves were removed, lack of glove use during care, not washing hands upon entering a resident's room and prior to leaving the resident's room after catheter care was done. The facility also failed to prevent cross contamination before, during, and after indwelling urinary catheter care. This deficiency affected 1 of 1 resident who was reviewed with an indwelling urinary catheter. (Resident # 52).</p>	F 0441	<p><u>Corrective Action for Affected Residents:</u> Resident # 52 received a catheter cover bag to place the catheter drainage bag inside of and to prevent the drainage bag from touching the floor. CNA #1, RN#12, and CNA#3 were in-serviced on catheter care, handling and positioning of catheter drainage bag and tubing, and hand washing and glove use, to prevent the spread of infection and cross contamination specific to providing Resident #52 catheter care. <u>Corrective Action for Potentially Affected Residents:</u> An audit of all residents who have a catheter was completed by Nursing Supervisors to identify any other affected residents and infection control issues and/or trends. Any</p>	09/16/2016

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	<p>Findings include:</p> <p>On 08/15/2016 at 11:08:00 AM Resident #52 was observed in her room sitting in her wheel chair. The resident's indwelling urinary catheter tubing was on the floor under the resident's wheel chair and the catheter bag was in a cloth bag attached under the bottom of the resident's wheel chair.</p> <p>On 8/15/16 at 11:35 A.M. Resident #52 was observed in her room sitting in her recliner chair. The resident's catheter tubing was on the floor by the resident's feet.</p> <p>On 8/15/16 at 2:15 P.M. the resident was observed sitting in her room in her recliner chair. The resident's catheter bag was not covered in a cloth bag and was hooked on the right side of the resident's recliner chair and the bottom of catheter bag was touching the floor.</p> <p>On 08/17/2016 at 11:38:01 A.M. with RN #12, observed Resident #52 sitting in her room in the recliner and the Resident's catheter bag was not in the cloth bag, and was sitting on the floor. RN #12 was interviewed indicated the catheter bag and tubing should not be on the floor.</p>				<p>affected residents will be provided with the appropriate interventions and staff education at the time of the findings. <u>Measures for Prevention:</u> All nursing personnel will be in-serviced on the facility's infection control policy specific to peri and catheter care, glove use, and hand washing. Nursing personnel will be re-trained on providing proper peri and indwelling urinary catheter care, handling of the catheter tubing and drainage bag, and proper hand washing and glove use to prevent the spread of infection and cross contamination, to include, repeat demonstration by staff. Staff competencies checks for nursing personnel, specific to, peri and catheter care, hand washing and glove use, will be completed by the facility's Staff Development Coordinator and will be ongoing. <u>QA for Prevention:</u> The facility's Licensed Nursing personnel will be responsible for ensuring that resident's catheter care is provided per the facility's catheter care and infection control policy to prevent the spread of infection and cross contamination with oversight from the Director of Nursing, Unit Managers, and Staff Development Coordinator. Results of the facility's infection rate and trends, review of residents utilizing foley catheters, and plan of correction to ensure continued monitoring and prevention to minimize the risk of infections will be reviewed</p>		

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	<p>Interview with Director Nursing Service (DNS) on 08/17/2016 at 2:33:35 P.M. indicated the catheter bag and tubing should never be on the floor.</p> <p>On 8/18/16 at 2:00 P.M. Resident #52 was observed receiving indwelling urinary catheter care with CNA #1 and CNA #3. Prior to starting the resident's care CNA #3 exited the resident's room and re-entered the resident's room without washing her hands and did not don gloves prior to the resident's catheter care. CNA #3 assisted the resident to turn on her side and proceeded to removed the resident's pants. CNA #3 touched the resident's bare skin on her legs without wearing gloves. CNA #1 washed her hands for 20 seconds and donned gloves CNA #1 proceeded to empty the urinary indwelling catheter with no concerns observed. CNA #1 then removed her gloves, washed her hands, and donned gloves. CNA #1 washed the resident's abdominal folds with soap and water and patted them dry with a towel. With a clean washcloth the catheter tubing was washed with peri wash from the meatus 4 inches down the urinary catheter. After urinary catheter care was done CNA # 3 with her bare hands and CNA #1 with gloves still on lifted the resident up in bed and touched the resident's lift pad. CNA #1 with gloves</p>		monthly by the facility's Quality Assurance Committee.				

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	<p>still on handed Resident #52 her call light. CNA #3 touched the resident's pillow with her bare hands after the catheter care was done. Then CNA #3 left the resident's room without washing her hands.</p> <p>CNA #1 then picked up her supplies and removed her gloves and washed her hands for 20 seconds before she left the room.</p> <p>An interview on 8/19/16 at 9:00 A.M. with LPN #8 indicated CNA #3 should have washed her hands and donned gloves upon entering the resident's room, prior to assisting with the resident's care and before touching the resident's clothing and bare skin. LPN #8 indicated CNA #3 should have washed her hands prior to touching the resident's pillow. CNA #1 should have removed gloves and washed her hands prior to touching the resident's call light. LPN #8 indicated CNA #3 should have washed her hands prior to leaving the resident's room after care was done.</p> <p>The current undated policy "Hand Hygiene" received from the DNS on 8/17/16 at 1:20 P.M. indicated "All employees of are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by accepted professional</p>			

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F 0463	<p>practice. Employee hands should, at a minimum, be washed before and after resident contact...and after removing gloves."</p> <p>The current policy titled "Catheter Care revised on 7/2015" received from the DNS on 8/18/16 at 3:00 P.M., indicated</p> <ol style="list-style-type: none"> <li>1. Gather equipment</li> <li>2. Explain procedure to resident</li> <li>3. Put on gloves</li> <li>4. Provide perineal care by cleaning front to back a d (sic) (and) center of perineum to thigh.</li> <li>5. Cleanse catheter by washing 4 inches from the meatus out</li> <li>6. Remove gloves and wash hands</li> <li>7. Make sure resident is in comfortable position." <p>The current policy "Care of Closed Urinary Drainage System..." revised: February 2015 received from the DNS on 8/17/16 at 1:20 P.M., indicated</p> <p>Procedure:</p> <p>"C...2. Maintain drainage bag covered for dignity.</p> <p>E...4... Do not allow drainage bag to touch floor."</p> <p>3.1-18(l)</p> <p>483.70(f)</p> </li></ol>			

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SS=D Bldg. 00	<p><b>RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</b></p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident's call light was functioning correctly.</p> <p>This deficiency affected 1 of 1 resident whose call light was not functioning correctly in a sample of 35 (Resident #52).</p> <p>Findings include:</p> <p>On 8/15/16 at 11:03 A.M. Resident #52's call lights in her room and in the resident's bathroom were both tested and the call light in her room was not lighting up in the hallway when tested.</p> <p>On 8/15/16 at 11:05 A.M. CNA #4 entered the resident's room to answer the bathroom call light and indicated Resident #52's call light in the room was not lighting up in the hallway. CNA #4 was observed to test the call light in the resident room and the call light did not light up in the hallway and was not sounding. CNA #4 indicated they would let maintenance know the resident's room call light was not working.</p>	F 0463	<p><u>Corrective Action for Affected Residents:</u> Resident #52 call light box affixed outside of Resident #52 room was repaired and checked for proper function by the Maintenance Director on 8/15/16. Resident #52 call light did continue to function properly at the nurse's station which allowed staff to be notified, however, the fixture was not illuminating outside of the resident's room. <u>Corrective Action for Potentially Affected Residents:</u> An audit of the facility's call light system will be completed by the Maintenance Director on 09/07/16 to identify any affected call lights noted to be inoperable or not functioning properly. Any affected call lights noted to be inoperable or not functioning properly will be repaired immediately. <u>Measures for Prevention:</u> The facility's Resident Call System policy was reviewed by the Interdisciplinary Team and revisions were made to the Resident Call System policy. Facility personnel will be in-serviced on the facility's revised Resident Call System policy. The revised Resident Call System policy will also be reviewed with residents. <u>QA for Prevention:</u> The Maintenance</p>	09/16/2016

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	<p>On 8/15/16 at 11:15 A.M. the Maintenance Director was observed in Resident #52's room and checked the resident call light in her room.</p> <p>On 08/16/2016 at 8:38:58 A.M. Resident #52 indicated the call light in her room was not working on Sunday night (8/14/16) and the resident had told a CNA but did not know the CNA's name or the shift the CNA worked. The resident indicated on Sunday night 8/14/16, if she needed help she would call out for someone.</p> <p>On 8/19/16 at 10:00 A.M. an interview with the Maintenance Director indicated he was not aware the call light in Resident #52's room was not functioning. The Maintenance Director indicated there was a form "...Repair/Cleaning Requisition Log" kept at the nurses station and there was no documentation Resident #52's call light was not working.</p> <p>The current policy for "Answering Call Light" revised on 8/2016 was received from the DNS on 8/19/16 at 12:45 P.M., Procedure indicated "H. If, inoperable or malfunctioning call light, notify maintenance and charge nurse; and give resident alternate form of call system such as a call bell."</p>		<p>Director will be responsible for ensuring resident call systems/lights are in full working order per the facility's policy with oversight from the Administrator and Interdisciplinary Team. Resident Call light and/or Resident Call System issues will be monitored and reviewed monthly by the facility's Quality Assurance Committee to ensure staff are aware of and in compliance with the Resident Call System policy.</p>	

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