

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2016
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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00186428.</p> <p>Complaint IN00186428 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 17, 18, 22, 23, 24, 2015</p> <p>Facility number: 000069 Provider number: 155148 AIM number : 100288980</p> <p>Census bed type: SNF: 7 SNF/NF: 88 Total : 95</p> <p>Census payor type: Medicare: 10 Medicaid: 73 Other: 12 Total: 95</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The creation and submission of this Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan ofCorrection be considered the Letter of Credible Allegation of Compliance andrequests a desk review in lieu of a post survey review.</p>	
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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>Quality review completed on February 25, 2016 by #02748.</p> <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</p>			

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	<p>(MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a comprehensive, accurate assessment was completed for 2 of 33 residents reviewed during Stage 2 of the survey. The assessment did not indicate a resident was receiving hospice services and the assessment did not indicate a resident was receiving an antipsychotic medication. (Resident #56, Resident #74)</p> <p>Findings include:</p> <p>1. On 2/22/16 at 8:33 a.m., Resident #56 was observed lying in bed. The resident indicated he was doing well that morning.</p> <p>On 2/22/16 at 9:00 a.m., Resident #56's clinical record was reviewed. Resident #56's diagnoses included, but were not limited to, congestive heart failure and chronic airway obstruction.</p> <p>The most recent signed physician's recapitulation orders, signed 1/8/16, included, but were not limited to: Resident is hospice care with admit diagnosis of CHF (congestive heart failure). The order was dated 5/19/15.</p>	F 0272	<p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident#56's MDS was modified to reflect hospice services. ·Resident#74's MDS was modified to reflect antipsychotic use. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·All residents will be audited to ensure all MDS assessments match current antipsychotic use and/or hospice services by March 14, 2016. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·The MDS/designee will conduct a full house audit of all residents to ensure all MDS assessments match current antipsychotic use and/or hospice services. ·DNS/designee will conduct in-service with MDS by March 14, 2016 on ensuring proper antipsychotic use and/or hospice service status is documented on 	03/14/2016
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	<p>The Hospice documentation was reviewed. The Patient Information section, indicated the resident's admission date to hospice services was 2/19/15.</p> <p>The Care Plans included, but were not limited to: Resident requires hospice related to chf, dated 3/2/15.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 11/13/15, indicated the resident did not have a prognosis of less than six months. The assessment further indicated the resident was not receiving hospice services.</p> <p>On 2/22/16 at 11:19 a.m., the MRE (Medical Records Employee) indicated Resident #56 had been on hospice services since the residents admission.</p> <p>On 2/24/16 at 8:29 a.m., the MDS Coordinator indicated the MDS Assessment had not indicated the resident was on hospice services because the facility did not have an explicit order the resident had a prognosis of less than six months.</p> <p>2. On 2/22/16 at 3:10 p.m., Resident #74 was observed sleeping in bed.</p>		<p>MDS assessments.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> MDS/designee will be responsible for the completion of Hospice Services CQI tool weekly times 4 weeks, monthly times 2 and then quarterly times 1. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. MDS/designee will be responsible for the completion of Antipsychotic Medication CQI tool weekly times 4 weeks, monthly times 2 and then quarterly times 1. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. <p>5. Date completion: March 14, 2016</p>		

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	<p>On 2/23/16 at 10:28 a.m., Resident #74's clinical record was reviewed. Resident #74's diagnoses included, but was not limited to: psychosis not due to substance or known physiological condition and Major Depressive Disorder.</p> <p>The most recent physician recapitulation orders, signed 1/8/16, included but was not limited to: Abilify (an antipsychotic medication), 2 mg (milligrams), at bedtime. The order start date was 12/18/15.</p> <p>A Gradual Dose Reduction, dated 1/23/16 had been approved to reduce the Abilify from 2 mg to 1 mg.</p> <p>The Care Plans included, but were not limited to: Resident is at risk for adverse side effects related to the use of psychotropic medications, antidepressant, antipsychotic. The start date for the care plan was 12/4/14.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 1/22/16, indicated the resident had not received an antipsychotic medication during the 7 day assessment period.</p> <p>On 2/24/16 the MDS Coordinator</p>			

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F 0323 SS=D Bldg. 00	<p>indicated the resident had received an antipsychotic during the assessment period.</p> <p>On 2/24/16 at 12:55 p.m., the DON provided the "Resident Assessment" policy, dated 1/2016. The policy included, but was not limited to: It is the policy of [Name of Facility] to conduct an initial and periodic comprehensive as well as a no less than quarterly, accurate, standardized reproducible assessment of each resident's functional capacity.....</p> <p>3.1-31(a)</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.</p> <p>Based on interview, observation, and record review, the facility failed to ensure 1 of 4 residents reviewed for accidents, had implemented all of the interventions planned to prevent accidents. (Resident #97)</p> <p>Findings include:</p>	F 0323	<p>F323 Free of Accident/Hazards/Supervision/Devices</p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <p>·Resident #97 with colored sign</p>	03/14/2016

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	<p>During an interview on 2/18/16 at 11:06 a.m., LPN # 1 indicated Resident #97 had fallen 5 (five) times in the last month. LPN #1 indicated the resident was quick and had fallen numerous times in the past year. LPN #1 indicated Resident #97 had received a hematoma to the back of her head on 1/25/16. LPN #1 indicated the resident had skin tears in the past from her falls.</p> <p>During an observation on 2/18/16 at 11:12 .a.m., Resident #97 was observed to be sitting on a sofa in the secured unit's lobby with her husband, sleeping. Resident #97 was observed to have on socks with no grippers on the sole.</p> <p>During an observation on 2/22/16 at 9:23 a.m., Resident #97 was observed to be sitting in the secured unit lobby sleeping. The resident's room door had a picture of a football and 2 (two) small valentine decorations on it. A colored sign with the residents name was not observed.</p> <p>During an observation on 2/22/16 at 2:23 p.m., Resident #97 was observed to be lying in bed. No night light was observed to be on or in the room. A pressure pad alarm was under the resident but was not turned on. The call light was under the bed.</p>		<p>with name placed on door, call light placed within reach, pressure pad placed.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · All residents with fall interventions have been reviewed with all interventions in place <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · DNS/designee will in-service nursing staff on fall intervention/fall program by March 14, 2016 <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · DNS/designee will be responsible for the completion of Fall Program CQI tool weekly times 4 weeks, monthly times 2 and then quarterly times 1. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. <p>5. Date completion: March 14,</p>		

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	<p>During an interview on 2/22/16 at 2:25 p.m., CNA #1 indicated the alarm had not been turned on. CNA #1 indicated the resident would climb out of bed quickly.</p> <p>The clinical record for Resident #97 was reviewed on 2/22/16 at 8:23 a.m. Resident #97 had diagnoses including, but not limited to dementia with behavior disturbances, anxiety state, depressive disorder, and macular degeneration. A significant change MDS (Minimum Data Set) assessment, dated 1/20/16, indicated a staff assessment for the mental status indicated the resident was severely impaired cognitively. The MDS indicated Resident #97 was an extensive assist of two person for bed mobility and transferring. The MDS further indicated Resident #97 required supervision with set up help only for locomotion.</p> <p>A care plan, with a start date of 11/13/13, indicated the resident was at risk for falls due to impaired cognition and vision, and poor safety awareness. The care plan interventions included, but were not limited to, as followed: provide a visual aide on colored paper outside own room with name on it pressure alarm to bed check placement and function every shift night light in room</p>		2016	

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F 0329 SS=D Bldg. 00	<p>call light in reach non skid footwear</p> <p>On 2/24/16 at 1:06 p.m. a policy was received titled "Fall Management Program" and dated 2/15 which indicated a care plan will be developed at time of admission specific to each resident's fall risk factors. A fall event will be initiated as soon as the resident has been assessed and cared for, the report will identify possible root causes of the fall and provide immediate interventions.</p> <p>3.1- 45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic</p>			

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	<p>drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications. Resident behaviors were not being tracked for 1 of 5 residents reviewed for unnecessary medications. (Resident #100)</p> <p>Findings include:</p> <p>On 2/22/16 at 8:52 a.m., Resident #100's clinical record was reviewed. Resident #100's diagnoses included, but were not limited to, dementia with lewy bodies and senile psychosis.</p> <p>The physician's recapitulation orders, signed 1/15/16, included, but was not limited to: Risperdal (an antipsychotic medication) 0.5 mg (milligrams), by mouth, twice daily.</p> <p>A Progress note, dated 4/6/15, indicated the Risperdal had been reduced to 0.25 mg twice daily.</p>	F 0329	<p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? ·Resident #100 placed on behavior tracking.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken ·All residents on have the potential to be affected by the alleged deficient practice. ·All residents audited to ensure behavior care plans and behavior tracking is in place by March 14, 2016.</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. ·All residents that require behavior monitoring will be audited by SSD/designee to ensure that behavior care plans and behavior tracking is in place by March 14, 2016 ·ED/designee will conduct an in-service with SSD on behavior management policy by March 14, 2016.</p>	03/14/2016

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	<p>An Event, dated 5/10/15, indicated the resident had voiced suicidal thoughts.</p> <p>An Event, dated 6/11/15, indicated the resident had been making false statements.</p> <p>An Event, dated 6/13/15, indicated the resident's Risperdal had been increased to 0.5 mg twice daily, related to the resident's increased behaviors of making false statements and suicidal ideation.</p> <p>The Behavior Administration History, dated 12/1/15 through 12/31/15 and 1/1/16 through 1/31/16, lacked behavior tracking for Resident #100's false statements and/or suicidal ideation.</p> <p>On 2/24/16 at 8:48 a.m., the DON indicated it was odd these behaviors were not on the Behavior Administration History.</p> <p>On 2/24/16 at 9:59 a.m., the DON indicated these behaviors had been added to the Behavior Administration.</p> <p>On 2/24/16 at 12:55 p.m., the DON provided the "Behavior Management Policy", updated 1/2016. The policy included, but was not limited to:All residents who are taking (either routinely or as needed) antipsychotic, anxiolytic,</p>		<p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>·SSD/designee will be responsible for the completion of Behavior Management CQI tool weekly times 4 weeks, monthly times 2 and then quarterly times 1. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date of completion: March 14, 2016</p>	

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F 0441 SS=D Bldg. 00	<p>sedative/hypnotic, or anticonvulsant medication (used for behaviors not seizures) are to have a behavior monitoring program and corresponding care plan in order to assist in assessing the efficacy of both interventions and medication use.</p> <p>3.1-48(a)(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</p>			

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	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure hand hygiene was performed after gloves had become visibly soiled with body fluid for 1 of 9 residents observed for care. (Resident #3, CNA #2)</p> <p>Findings include:</p> <p>On 2/23/16 at 9:02 a.m., CNA #2 was observed to provide incontinence care for Resident #3. CNA #2 entered the residents room, pulled the privacy curtain, lowered the bed, and removed the residents sheet. CNA #2 donned gloves. No hand hygiene was observed upon entrance to Resident #3's room or prior to CNA #2 donning gloves. CNA #2 removed Resident #3's brief and assisted Resident #3 to roll to the left side. CNA #2 pulled Resident #3's brief. A bowel movement was observed in</p>	F 0441	<p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? ·Resident#2 monitored for infectious process with no noted issues.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken ·All residents have the potential to be affected by the alleged deficient practice. ·DNS/designee will perform hand washing, perineum care, and gloving skills validations on nursing staff by March 14, 2016.</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. ·DNS/designee will conduct in-service with nursing staff on</p>	03/14/2016

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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710		
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	<p>Resident #3's brief. CNA #2's had begun cleansing Resident #3's buttocks. CNA #2's gloves had become visibly soiled with feces. CNA #2 obtained additional cleansing wipes and utilized the wipes to cleanse the soiled gloves. CNA #2 finished cleansing Resident #2's buttocks and pulled the rest of the brief out from underneath Resident #2.</p> <p>CNA #2 obtained a trash bag from his pocket and placed the soiled brief and cleansing wipes in the bag. CNA #2 removed the soiled underpad from underneath Resident #3.</p> <p>CNA #2 removed his gloves and donned a clean pair. No hand hygiene was observed in between glove changes. CNA #2 obtained a cleansing wipe and cleansed Resident #3's perineal area. Feces was observed again. CNA #2 proceeded to cleanse Resident #3's perineal area and his gloves had become visibly soiled.</p> <p>CNA #2 utilized a clean cleaning wipe to cleanse the soiled gloves and utilized the same wipe to continue cleansing Resident #3's perineal area. CNA #2 removed his gloves and donned a clean pair. No hand hygiene was observed between glove changes.</p> <p>CNA #2 assisted Resident #3 to roll from side to side to place a clean brief underneath the resident. CNA #2 pulled Resident #3's gown down and covered</p>		<p>infection control practices by March7, 2016.</p> <p>·DNS/designee will perform hand washing, perineum care, and gloving skills validations tonursing staff by March 14, 2016.</p> <p>4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place</p> <p>·DNS/designee will be responsible for thecompletion of Infection Control CQI tool weekly times 4 weeks, monthly times 2and then quarterly times 1. The results of these audits will be reviewed by theCQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date of completion:March14, 2016</p>		

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	<p>the resident up.</p> <p>CNA #2 removed his gloves, gathered the bags of soiled trash and linens and exited the room. As CNA #2 walked down the hallway, he engaged in conversation with an unidentified resident and they touched hands. CNA #2 then continued down the hallway to the soiled utility room to dispose of the soiled linens and trash. CNA #2 attempted to enter the bathroom of Room #134, which was the closest resident room to the soiled utility room. A resident was in the bathroom and CNA #2 exited the room. CNA #2 continued back to Resident #3's bathroom where he performed hand hygiene.</p> <p>On 2/24/16 at 9:05 a.m., RN #1 indicated hands should be washed in between dirty and clean tasks for forty seconds.</p> <p>On 2/24/16 at 12:55 p.m., the DON provided the "Hand Hygiene" policy, updated 12/2015. The policy included, but was not limited to: Wash hands when visibly soiled and to wash hands after body fluid exposure risk.</p> <p>3.1-18(b)(1) 3.1-18(l)</p>			

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review the facility failed to provide a safe, functional and comfortable environment for residents, staff, and the public in that rooms had screws sticking up from commode, toilet paper rolls were missing, sticky floors, bathrooms which smelled like urine, closet doors missing, in 12 of 35 rooms observed. (Rooms 108, 110, 114, 126, 140, 141, 143, 145, 147, 150, 162, 169)</p> <p>On 2/18/16 from 10:00 a.m. to 4:00 p.m. and 2/19/16 from 8:00 a.m. to 2:00 p.m., the following rooms were observed during Stage 1 or resident observation.</p> <p>The following was observed:</p> <p>1. Room 108: Had tile missing behind the sink, caulking at base of commode has brown stains on it. On 2/23/16 at 2:18 p.m. the tile was fixed, but the caulking at the base of the commode had brown stains on it. This is a private room.</p> <p>2. Room 110: The door to bathroom had</p>			F 0465	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Room 108 tile behind sink repaired, caulking around toilet replaced. ·Room 110 doors chipping repaired, call light replaced with longer cord. ·Room 114 doors chipping repaired, wall board repaired in closet. ·Room 140 outlet cover repaired. ·Bathrooms for rooms 141 & 143 deep cleaned, toilet screws capped, metal bar replaced. ·Bathrooms for rooms 145 & 147 deep cleaned. ·Room 150 tape marks removed, toilet screws capped, toilet paper holder placed, bolt/ (water line) on wall behind toilet covered. ·Bathrooms for rooms 160 & 162 toilet paper holder placed, faucet handle repaired, floor cleaned, bolt on wall behind toilet removed. ·Room 169 bathroom toilet paper holder placed, toilet screws capped. ·Room 126 bathroom toilet 		03/14/2016

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	<p>wood scraped off. The call light cord in the bathroom was only 3 inches long and hard to grasp. On 2/23/16 at 2:18 p.m. the room was found to be the same. This is a private room.</p> <p>3. Room 114: There was paint chipped around bathroom door frame, with closet door opened and wall board scrapped. On 2/23/16 at 2:19 p.m. the same was found. This is a private room.</p> <p>4. Room 140: An electrical socket outlet above the bed has a plastic covering, to protect resident from accidentally sticking her fingers in the socket, which can be opened by resident. On 2/23/16 at 19:59 p.m. the socket covering was found to be the same.</p> <p>5. Room 141 and 143 in the bathroom which is shared, had a rust stain running down tile to floor, from a missing metal hanger for clothes. On 2/23/16 2:21 p.m. the same was found.</p> <p>6. Room 145 and 147 shared the bathroom, an odor was present of urine. One of the residents indicated the odor was due to his roommate who has accidents in the bathroom. On 2/23/16 at 2:26 p.m. the bathroom still smelled of urine.</p>		<p>caulking replaced.</p> <ul style="list-style-type: none"> ·Missing closet doors ordered. Work to be completed by April 1, 2016. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·Maintenance supervisor completed facility wide round to correct any safety or environmental issues. ·Housekeeping supervisor completed facility wide round to clean any environmental issues. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·ED/designee will conduct an in-service with housekeeping and maintenance staff on cleaning/repairs scheduled by March 14, 2015. ·Maintenance Supervisor/designee will complete daily rounds of the entire facility Monday-Friday and as needed. ·Housekeeping Supervisor/designee will complete daily rounds of entire facility Monday-Friday and as needed. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what</p>		

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	<p>7. Room 150: Tape marks were on bathroom door, there was exposed commode screws, a missing toilet paper holder, a bolt sticking out of bathroom wall above commode On 2/23/16 at 2:26 p.m. the areas remained the same.</p> <p>8. Room 162 and 160 which share a bathroom had no toilet paper holder, the faucet handle turns completely around and the water is slow. The bedroom and bathroom floor were sticky, and there was a bolt protruding above commode in bathroom. In room 162 there were no doors on the closet. On 2/23/16 2:34 p.m. the same was found.</p> <p>9. Room 169: There was no toilet paper holder, the commode screws were exposed on both sides. On 2/23/16 at 2:27 p.m. the toilet paper holder was in place, but screws at base of commode were exposed.</p> <p>10. On 2/17/16 at 2:53 p.m., Room #126 was observed. The caulking at the base of the commode was observed to be yellow and black. On 2/24/16 at 9:03 a.m., the same was observed. The bathroom was shared by 4 residents.</p> <p>On 2/24/16 at 10:30 a.m., the Environmental Services Supervisor indicated toilets are cleaned down to the floor on a daily basis.</p>		<p>quality assurance program will be put into place?</p> <p>·ED/designee will be responsible for the completion of Laundry/Housekeeping Cleaning Schedules CQI tool weekly times 4 weeks, monthly times 2 and then quarterly times 1. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>·ED/designee will be responsible for the completion of Environmental Safety CQI tool weekly times 4 weeks, monthly times 2 and then quarterly times 1. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>·ED/designee will be responsible for the completion of Resident Care Rounds CQI tool weekly times 4 weeks, monthly times 2 and then quarterly times 1. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date of completion: March 14, 2016</p>		

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	<p>On 2/24/14 at 9:45 a.m. an interview with Maintenance indicated he does not keep a log on checking rooms. He indicated if there is a problem in a room the CNA or Nursing will fill out a work order or a note specifying the problem.</p> <p>On 2/24/16 at 9:58 a.m. a job description was received for Maintenance which indicated a facility specific preventative maintenance schedule for resident rooms and common areas is developed.</p> <p>On 2/14/16 at 10 a.m. a policy was received which indicated the rooms should be checked daily for toilet tissue, clean and disinfect bathroom, sweep and be moped. A weekly schedule indicated the cove base should be wiped down, edging and corners where accessible.</p> <p>3.1- 19(f)</p>			