

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/22/2014
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NAME OF PROVIDER OR SUPPLIER  WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 18, 19, 20, 21, &amp; 22, 2014</p> <p>Facility number: 000162 Provider number: 155261 AIM number: 100284300</p> <p>Survey Team: Holly Duckworth, RN, TC Rita Mullen, RN Maria Pantaleo, RN Bobette Messman, RN</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census Payor type: Medicare: 5 Medicaid: 39 Other: 11 Total: 55</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on August 28, 2014.</p>	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Williamsburg Health Care that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Williamsburg Health Care.	

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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F000278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments regarding the prognosis of a resident on end of life care, and accurately code a</p>	F000278	<p><b>F278 – Assessment Accuracy/Coordination/Certified</b> I. 1. Resident #45 received comfort care per physician's orders and has since passed so the appropriate</p>	09/19/2014
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	<p>resident for incontinence for 1 of 3 residents reviewed for death in the facility within 30 days of admission to the facility and 1 of 3 residents reviewed for incontinence (Resident #45 and #17).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #45 was reviewed on 8/20/2014 at 12:45 p.m. Diagnoses included, but were not limited to, end of life care, myocardial infarction, congestive heart failure, chronic renal insufficiency, atrial fibrillation, pacemaker, reflux disease, coronary artery disease, diabetes mellitus, hyperlipidemia, traumatic subarachnoid hemorrhage, cerebral contusion, chronic renal failure, and depression.</p> <p>The resident was admitted to the facility on 4/18/2014 and readmitted on 5/12/2014 with the diagnosis, end of life care.</p> <p>A physician's order, dated 5/12/2014, indicated diagnoses end of life care, traumatic subarachnoid hemorrhage, cerebral contusion, chronic renal failure, congestive heart failure.</p> <p>A physician's order, dated 5/15/2014 "...comfort care only/ all meds stopped except for comfort care...."</p>		<p>prognosis cannot be certified by the physician in order to comply with MDS guidelines. 2. Resident #17 has since been reassessed for a Quarterly MDS that accurately reflects her continence status. II. 1. In an effort to ensure the continued accuracy of coding for a terminal condition on the MDS, each resident currently receiving end of life care or comfort care has been reassessed and necessary actions taken as warranted, including receiving certification from the physician that the resident is anticipated to have 6 months or less to live. 2. As all residents experiencing incontinence could be affected, the MDSs for these residents were reviewed and compared to their Bladder Assessments: III. 1. As a means to ensure ongoing compliance with correctly assessing a resident for a terminal condition on the MDS, a form has been created for the physician to complete when ordering comfort care or end of life care to certify that the resident is anticipated to live for 6 months or fewer should the terminal disease run its course. Recertification of the terminal condition shall be conducted on a quarterly basis or more frequently if there is a significant change in condition. Monitoring for compliance will be conducted by the DON or her designee. Continued completion of the</p>				

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F000309 SS=D	<p>A Significant Change MDS assessment, dated 5/16/2014, indicated Resident #45 did not have a prognosis of less than six months.</p> <p>During an interview on 8/20/2014 at 3:00 p.m., with the Director of Nursing, she indicated the resident was care planned and received end of life care but no prognosis of six months or less from the physician was obtained by the facility.</p> <p>During an interview on 8/22/2014 at 1:15 p.m., the MDS Coordinator indicated without a physician's verification indicating the resident only has six months or less to live, the MDS cannot be coded for a prognosis of less than six months. A physician's order, dated 5/15/2014 "...comfort care only/ all meds stopped except for comfort care..." is not an indication of a physician's verification the resident has six months or less to live. The resident was not assessed and coded for a prognosis of less than six months.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>		<p>quarterly reassessments and subsequent action(s) taken will be reported to the Administrator. 2. As a means to ensure ongoing compliance with correctly indicating a resident's continence status on the MDS, an elimination tracking form will be used to correctly monitor and assess a resident's continence. The elimination tracking will be completed on a quarterly basis or more frequently if there is a significant change in condition. Monitoring for compliance will be conducted by the DON or her designee. IV. 1-2. As a means of quality assurance, results of the aforementioned assessments and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. 1-2. Evidence of the form for certification of prognosis for residents receiving end of life care or comfort care is provided in Attachment A. Evidence of the audit and monitoring of accuracy of coding for continence status and prognosis is provided in Attachment B. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F278.</p>	

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to accurately assess the prognosis of a resident on end of life care on the Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for death within 30 days of admission to the facility (Resident #45).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #45 was reviewed on 8/20/2014 at 12:45 p.m. Diagnoses included, but were not limited to, end of life care, myocardial infarction, congestive heart failure, chronic renal insufficiency, atrial fibrillation, pacemaker, reflux disease, coronary artery disease, diabetes mellitus, hyperlipidemia, traumatic subarachnoid hemorrhage, cerebral contusion, chronic renal failure, and depression.</p> <p>The resident was admitted to the facility on 4/18/2014 and readmitted on 5/12/2014 with the diagnosis, end of life care.</p> <p>A physician's order, dated 5/12/2014, indicated diagnosis end of life care, traumatic subarachnoid hemorrhage, cerebral contusion, chronic renal failure,</p>	F000309	<p><b>F309 – ProvideCare/Services for Highest Well Being I.</b></p> <p>1. Resident #45 received comfort care per physician's orders and has since passed so the appropriate prognosis cannot be certified by the physician in order to comply with MDS guidelines.</p> <p>II. In an effort to ensure the continued accuracy of assessing for a terminal condition with a prognosis of 6 months or less to live, each resident currently receiving end of life care or comfort care has been reassessed and necessary actions taken as warranted, including receiving certification from the physician that the resident is anticipated to have 6 months or less to live. III. As a means to ensure ongoing compliance with accurately assessing a resident for a prognosis of 6 months or less to live, a form has been created for the physician to complete when ordering comfort care or end of life care to certify that the resident is anticipated to live for 6 months or fewer should the terminal disease run its course. Recertification of the terminal condition shall be conducted on a quarterly basis or more frequently if there is a significant change in condition. Monitoring for compliance will be conducted</p>	09/19/2014

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F000329	<p>and congestive heart failure.</p> <p>A physician's order, dated 5/15/2014 "...comfort care only/ all meds stopped except for comfort care....".</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 5/16/2014, indicated Resident #45 did not have a prognosis of less than six months.</p> <p>During an interview on 8/20/2014 at 3:00 p.m., with the Director of Nursing, she indicated the resident was care planned and received end of life care.</p> <p>During an interview on 8/22/2014 at 1:15 p.m., the MDS Coordinator indicated without a physician's verification indicating the resident only has six months or less to live, the MDS cannot be coded for a prognosis of less than six months. A physician's order, dated 5/15/2014 "...comfort care only/ all meds stopped except for comfort care...." is not an indication of a physician's verification the resident has six months or less to live. The resident was not assessed and coded for a prognosis of less than six months.</p> <p>3.1-37(a)</p> <p>483.25(l)</p>		<p>by the DON or her designee. Continued completion of the quarterly recertifications and subsequent action(s) taken will be reported to the Administrator. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the form for certification of prognosis for residents receiving end of life care or comfort care is provided in Attachment A. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F309.</p>		

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SS=D	<p><b>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>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 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 record review and interview, the facility failed to monitor a resident for behaviors prior to increasing a daily risperdal (antipsychotic) dose for 1 of 5 residents reviewed for unnecessary medications (Resident #16).</p> <p>Findings include:</p> <p>The clinical record of Resident #16 was reviewed on 8/21/14 at 10:30 a.m. Diagnoses included, but were not limited to, high blood pressure and Alzheimer's dementia with agitated behavior.</p>	F000329	<p><b>F329 – Drug Regimenis Free from Unnecessary Drugs I.</b></p> <p>Please let it be noted that resident #16 was not negatively affected as a result of the increase in Risperdal. II. As all residents could be affected, the following corrective actions were taken: III. As a means to ensure ongoing compliance with ensuring an antipsychotic is not initiated or increased without need, nursing staff hasbeen inserviced in regard to monitoring behaviors and documenting accordingly. Following education, resident orders shall be audited once</p>	09/19/2014	

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	<p>A Medication Regimen Review Report, dated 3/25/14, indicated Resident #16 had been on risperdal (antipsychotic) 0.25 milligrams (mg) every a.m., and 1 mg at night since 5/27/10. A dose reduction was requested for risperdal 0.25 mg every a.m., and 0.5 mg at night. The physician agreed and the order was signed on 3/26/14.</p> <p>Behavior/Mood Monitoring Forms dated for the months of February, March and April 2014, indicated no behaviors for February, eight episodes of behaviors in March and three episodes of behavior in April.</p> <p>During the dose reduction time period, March 20, 2014 to April 23, 2014, Resident #16 had six episodes of yelling out.</p> <p>A "Desk 2" communication, dated 3/1/14 to 3/31/14, indicated "Nursing is pursuing pain as a factor behind the repetitive yelling. Still spelling words loudly @ [at] times - more vocal since med [medication] decreased yelling frequently."</p> <p>A "Desk 2" communication, dated 4/1/14 to 4/30/14, indicated recently reduced risperdal and the resident was not having</p>		<p>weekly to confirm compliance with the documentation of several resident behaviors prior to initiating or increasing the dosage of an antipsychotic. Should non-compliance be observed, re-education and/or disciplinary action shall be taken as warranted. Monitoring shall be conducted by the Director of Nursing of her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the monitoring is provided in Attachment C. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F329.</p>	

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	<p>behaviors.</p> <p>A review of Nursing notes, dated 3/23/14 to 4/30/14, indicated Resident #16 had one episode, on 3/28/14 at 2:50 a.m., of "Yelling out" for help. Notes indicated the resident was being treated for a bowel infection and diarrhea during the gradual dose reduction of risperdal.</p> <p>A Physician's order, dated 4/23/14, indicated a failed reduction of risperdal and to resume previous dose of 1 mg risperdal every p.m., and to continue same a.m. dose.</p> <p>During an interview with the Social Service director, on 8/27/14 at 2:00 p.m., she indicated she had no other record of behaviors for Resident #16 except yelling out on 3/26/14 three times and 4/3/14 three times.</p> <p>3.1-48(a)(4)</p>				

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F000371 SS=E	<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 and interview, the facility failed to ensure the kitchen area had a hand washing station that was accessible, dishwasher that was secure, equipment that was clean, walls and ceiling that were not cracked or chipped, and food that was prepared and temperature tested under sanitary conditions, for 1 of 1 kitchens. This deficiency had the potential to affect 54 of 55 residents who dine at the facility.</p> <p>Findings include:</p> <p>1.) During the initial kitchen tour with the Dietary Supervisor on 8/18/2014 at 9:20 a.m., the following was observed:</p> <p>a.) The hand washing sink inside the kitchen was clogged and slow draining.</p>	F000371	<p><b>F371 – Food Procure/Store/Prepare/Serve– Sanitary I.</b> The dietary manager was addressed regarding maintaining the kitchen in a sanitary manner and corrective action taken relative to items 1a–1h and 2 upon discovery. II. As all residents could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with ensuring sanitary conditions, staff received in-service training on kitchen cleanliness and food storage, including but not limited to, cleaning procedures, location of sanitary items, and replacement/repair of equipment. Following education provided, observations shall be conducted a minimum of weekly by the Human Resources and Maintenance Supervisor or her designee to confirm continued compliance. Should concerns be</p>	09/19/2014
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	<p>b.) The staff who entered the kitchen needed to cross the kitchen floor to wash their hands and apply hair nets.</p> <p>c.) The floor under the hand washing sink and the stepping stool located under the sink area were dirty.</p> <p>d.) The dishwasher hood was askew (not secured properly), and was taped together to maintain the hood over the dishwasher.</p> <p>e.) The walls and ceiling surrounding the dishwasher area were cracked and paint was peeling.</p> <p>f.) The ceiling above the clean dishes area was peeling and paint chips were on the floor area.</p> <p>g.) Lime was noted to be on the kitchen dishwasher, garbage cans and silverware equipment tray holder.</p> <p>h.) 1 of 1 plastic food serving carts, 3 tiered, was cracked with a hole in the center middle tray.</p> <p>2.) During the observation of food temperature readings for the lunch meal on 8/18/2014 at 10:40 a.m., Cook #1 wiped a used temperature thermometer on a wet towel. Cook #1 utilized 3 different temperature thermometers and</p>		<p>noted, re-education and/or disciplinary action shall be taken as warranted. IV. As a mean of quality assurance, the aforementioned monitoring shall be reported to the Administrator on a weekly basis. Continued monitoring and any necessary corrective measures initiated as a result of said monitoring shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the monitoring is provided in Attachment D. Due to the evidence provided, Williamsburg Health Care requests paper compliance for tag F371.</p>				

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	<p>performed the same procedure. Cook #1 then started to use the three wiped temperature thermometers to test additional food on the serving cart and was stopped before contaminating the food on the serving cart.</p> <p>During an interview with Cook #1 on 8/18/2014 at 10:45 a.m., she indicated she normally cleaned the temperature thermometers with sanitizing wipes. She indicated the kitchen was out of sanitizing wipes, so she was using a wet towel to clean the temperature thermometers. Cook #1 indicated she did not know what the policy or procedure indicated to use for the cleaning of temperature thermometers. Cook #1 indicated she was going to continue to utilize the wet towel to clean the temperature thermometers to test food temperatures on the serving cart. The Dietary Supervisor over heard the interview with Cook #1 and she stopped Cook #1 from contaminating the food on the serving cart. The Dietary Supervisor located sanitizing wipes for Cook #1 to utilize for the rest of the temperature testing process.</p> <p>During an interview with the Dietary Manager on 8/18/2014 at 11:06 a.m., she indicated sanitizing wipes were utilized to clean temperature thermometers. The</p>						

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F000431 SS=D	<p>Dietary Manager indicated the dishwasher hood had always been askew and taped because it did not fit on the dishwasher. The Dietary Manager indicated the dishwasher was at least 50 years old.</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>				

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	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure an outdated opened vial of PPD (Purified Protein Derivative) was removed from the Desk 2 medication refrigerator. This affected 1 of 2 medication storage areas observed.</p> <p>Findings include:</p> <p>During an observation on 8/19/14 at 4:40 p.m., one vial of PPD solution with an open date of 7/2/14 was found in the refrigerator.</p>	F000431	<p><b>F431 – Drug Records, Label/Store Drugs &amp; Biologicals I.</b> The expired vial of PPD solution was removed and disposed of. II. As all residents could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with ensuring removal of expired medications, the facility has in-serviced staff on the facility policy regarding medication storage. The DON conducted an audit to ensure removal and disposal of any other expired medications. To ensure ongoing compliance, observations shall be</p>	09/19/2014

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F000463 SS=D	<p>During an interview on 8/19/14 at 4:40 p.m., Registered Nurse #2 indicated the vial should not be in the refrigerator per policy.</p> <p>A policy, titled "Medication Storage in the Facility," obtained from Executive Director, received 8/20/14 at 12:17 p.m., documented "... It is the policy of the facility that medications, including liquids, ophthalmics, inhalents, etc. shall not be used beyond the manufacturers' expiration date, or beyond the use date as listed... Injectable products expire 28 days after the date opened...."</p> <p>3.1-25(m)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a resident's call light was in working condition for 1 of 28 residents observed for call lights(Resident #11).</p>	F000463	<p>conducted a minimum of twice monthly to confirm compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Director of Nursing or her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the in-servicing is provided in Attachment E. Evidence of the audit and monitoring is provided in Attachment F. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F431.</p> <p><b>F463 – Resident Call System – Rooms/Toilets/Bath</b> I. Resident 11's call light was replaced and was verified to be functional by the Administrator. II. As all residents could be affected, the</p>	09/19/2014			

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F000465 SS=E	<p>Findings include:</p> <p>During an observation on 8/19/14 at 11:15 a.m., the call light for Resident # 11 was found to be non functional.</p> <p>During an interview on 8/19/14 at 11:20 a.m., Licensed Practical Nurse #4 indicated the call light is the method by which residents call for assistance. She further indicated the call light in Resident #11's room was not working.</p> <p>During an environmental tour on 8/20/14 at 10:00 a.m., the Executive Director and the Maintenance Director also found the call light to be non functional.</p> <p>3.1-19(u)(1)</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.</p>		<p>following corrective action was taken: III. As a means to ensure ongoing compliance with ensuring a properly functioning call system, the facility has revised its procedure regarding monitoring of the call light system. Checking the resident's call system was added to each resident's medication administration record to be completed each shift by the nurse. Additionally, the maintenance department will check and inspect the resident call cords weekly. Monitoring for compliance will be conducted weekly by the Administrator or her designee. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the addition to the kardexes is provided in Attachment G-1 and G-2. Evidence of the monitoring is provided in Attachment H. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F463.</p>		

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	<p>Based on observation, interview and policy review, the facility failed to ensure residents rooms ,(#1, 2 ,3 ,4, 6, 7, 8,10,13,14,16,17,18,19, 38, 37, 39,41,42,43,44, 45, 47,48, 49,51,52, 53, 54, 55), were clean and in good repair for 30 of 41 rooms observed.</p> <p>Findings include:</p> <p>During an environmental tour on 8/21/14 at 10:00 a.m., accompanied by the Executive Director (ED) and the Maintenance Supervisor, the following was observed:</p> <p>Desk 1 wing:</p> <p>Room#</p> <p>38- entrance door gouged (lower one third of the door)</p> <p>37- entrance door gouged</p> <p>39- floor tile in resident's room was chipped</p> <p>41- entrance door gouged</p> <p>42- entrance door gouged, ceiling fan was black with dirt.</p> <p>43- wood railing on window wall severely chipped and gouged, floor fan blades and cage dirty, entrance door gouged</p> <p>44- floor tile chipped and broken</p> <p>45- dresser's front veneer chipped</p> <p>47- wood rail on door wall severely</p>	F000465	<p><b>F465</b>  <b>-Safe/Functional/Sanitary/Comfortable Environment I.</b> The maintenance department was addressed regarding maintaining the kitchen in a sanitary manner and corrective action taken relative to rooms #1, 2, 3, 4, 6, 7, 8, 10, 13, 14, 16, 17, 18, 19, 37, 38, 39,41, 42, 43, 44, 45, 47, 48, 49, 51, 52, 53, 54, and 55 upon discovery. II. As all residents could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with ensuring safe and sanitary conditions, staff received in-service training on facility cleanliness and safety, including butnot limited to, cleaning procedures, reporting damaged fixtures/structures, and replacement or repair of equipment. Following education provided, observations shall be conducted a minimum of weekly by the Administrator or her designee to confirm continued compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. IV. Continued monitoring and any necessary corrective measures initiated as a result of said monitoring shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of themonitoring is provided in Attachment I. Due to the evidence provided,Williamsburg Health Care requests paper compliance</p>	09/19/2014			

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	<p>chipped and gouged, bathroom door gouged, floor tiles cracked, both resident fans had dirty blades and cages</p> <p>48- fan blades dirty</p> <p>49- window check rail was found to be dirty and had multiple cobwebs</p> <p>51- window check rail dirty, floor tile in bathroom had severe rust stains</p> <p>52- entrance doors gouged, fans coated with thick dust, window check rail dirty with cobwebs</p> <p>53- window frames dirty with cobwebs</p> <p>54- entrance door gouged, large gouged area on lower third of door, bathroom floor tiles cracked, rust stained tiles under the sink, ceiling area around fan cracked and broken</p> <p>55- entrance door gouged</p> <p>Desk 2 wing:</p> <p>Room#</p> <p>1- plaster on corner cracked down to the steel frame, wood rail in room gouged</p> <p>2- wood rail on window wall gouged</p> <p>3- floor tiles at entrance of the room gouged</p> <p>4- entrance door gouged</p> <p>6- entrance door gouged</p> <p>7- entrance door gouged, floor tiles chipped and broken</p> <p>8- fan blades dirty</p> <p>10- floor tiles chipped</p> <p>13- wood rail gouged</p>		for tag F465.		

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	<p>14- wood rails on window wall gouged, bathroom floor tile around toilet gouged down to the second layer of flooring</p> <p>16- entrance door chipped, floor tile chipped</p> <p>17- entrance door gouged, sink in the bathroom had a rusted rim</p> <p>19- entrance door gouged, floor tiles chipped in resident's room, floor tiles in bathroom chipped</p> <p>During an interview on 8/21/14 at 11:30 a.m., the ED indicated the facility was in the process of remodeling and redoing all resident rooms and common areas. Depending on any issues that may arise, such as supply delivery, it was anticipated that the remodeling should be completed in approximately 2 years at the rate of 2-3 rooms per month.</p> <p>A policy, titled "Procedures for cleaning and sanitizing resident's rooms," obtained 8/21/14 at 1:27 p.m., indicated the resident rooms are to be cleaned thoroughly, beginning in the far corner of the room daily.</p> <p>3.1-19(f)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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