

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 16, 17, 18, & 19, 2015</p> <p>Facility number: 000155 Provider number: 155252 AIM number: 100266830</p> <p>Survey team: Anna Villain, RN-TC Barbara Fowler, RN Denise Schwandner, RN Diana Perry, RN (March 16 & 17, 2015)</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 13 Medicaid: 74 Other: 23 Total: 110</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 24, 2015 by Jodi Meyer, RN</p>	F 000		

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 323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident's environment remained free from accident hazards, in that, 9 of 17 rooms surveyed had water temperatures greater than 120 degrees and electrical equipment was plugged in near a water source. (Rooms 404, 405, 501, 505, 506, 507, 509, 100, 503)</p> <p>Findings include:</p> <p>1. On 3/16/15 between the hours of 10:00 a.m. and 2:00 p.m., during Stage 1 of Resident Observation, 7 of 15 rooms were found to have water temperatures greater than 120 degrees. Each room was measured with the same digital thermometer. The following rooms were found with these temperatures:</p> <p>Room 404-120.7 degrees Room 405-122.7 degrees Room 501-126.6 degrees Room 505-126.9 degrees Room 506-120.4 degrees</p>	F 323	<p>F323</p> <p>--F-- What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The use of the laser digital thermometer was stopped immediately. Water Temperatures are being taken with a standard digital thermometer.</p> <p>Room 100- The electrical pencil sharpener was removed from resident bathroom.</p> <p>Room 503- The electric razor was removed from resident bathroom.</p> <p>--How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected. Two rooms on each hall and each shower room will have water temperatures tested daily with the digital thermometer. 1x per week the maintenance department will check the accuracy of the digital thermometer against the reading on 1 other thermometer.</p> <p>-- What measures will be</p>	04/18/2015

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	<p>Room 507-126.1 degrees Room 509-125.2 degrees</p> <p>On 03/16/2015 3:38 p.m., the Maintenance Man #2 was notified of high water temperatures in resident rooms. The Maintenance Man #2 brought a laser digital thermometer and checked Room 401 and obtained 119 degrees, Room 505 and obtained 110 degrees and Room 507 and obtained 101 degrees. Maintenance Man #2 indicated the Maintenance Supervisor checked the water temperatures every morning with the digital laser thermometer. An inquiry was made requesting the temperature logs, which he was unsure how to access them. When Maintenance Man #2 checked the water heater, it was found the temperature at the mixing valve was set at 124 degrees. The Maintenance Man #2 turned down the valve, and burned himself on water pipe. The supply room with the water heater was locked, however, there was a key hanging on a chain down to the door lock.</p> <p>On 03/16/2015 4:15 p.m. the Administrator was notified of the water temperatures, she was unaware of any problems with the hot water.</p> <p>On 03/16/2015 4:17 p.m., the Maintenance Supervisor called back and</p>		<p>put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Laser digital thermometers will not be used to check water temperatures. The maintenance department will check water temperatures with a digital thermometer. For accuracy, that thermometer will be compared with the reading of one other thermometer 1x per week. All temperatures will be placed in Building Engines for monitoring. Maintenance will report any instances of out of range temperatures to the Executive Director. Executive Director will review temperatures in Building Engines weekly. Housekeeping and nursing staff are to observe for any inappropriate items in resident bathrooms daily and report any concerns immediately to the Director of Nursing or the Executive Director.</p> <p>--How will the corrective action(s) be monitored to ensure the deficient practice will not recur and what QA program will be put into place? Findings will be reported in QAPI monthly x6 months unless additional monitoring is deemed necessary at that time.</p> <p>--Systematic changes will be completed by: <u>April 18, 2015</u> **We are requesting paper compliance for F323</p> <p>-</p> <p>-</p>		

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	<p>indicated he used a Laser Digital Thermometer daily to check water temperatures and had no problems. He also indicated the 124 temperature is not a temperature set for water, but a mixing point of cold and hot water and turning it down would result in cold water.</p> <p>On 03/17/2015 8:21 a.m., the Maintenance Supervisor indicated the temperatures he had obtained that morning (3/17/15), were high and in correlation with the temperatures checked yesterday. He indicated he had checked the water temperatures with the Laser Digital Thermometer, a digital thermometer, and a mercury thermometer. The Maintenance Supervisor indicated the Laser Digital Thermometer was about 3 degrees less. He indicated he would be using the digital thermometer from now on. The boiler room and the thermometer which was turned down yesterday was observed. He indicated that valve should be turned down in very small increments, or the water temperature would drop significantly throughout the building, but the temperature of the water had been adjusted. The Maintenance Supervisor indicated that the water pipes are laid in the concrete floor of the building and are subject to outside temperatures also. He further indicated he would be checking</p>			

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	<p>the temperatures again today. A log was received from Maintenance Supervisor with water temperatures from last year.</p> <p>On 3/17/15 at 2:45 p.m., water temperatures were rechecked, using the same digital thermometer, and the following results were obtained:</p> <p>Room 404 - 110.8 degrees Room 405- 110 degrees Room 501 - 112.5 degrees Room 505 - 112.8 degrees Room 506 - 110 degrees Room 507 - 108 degrees Room 509 - 111.6 degrees</p> <p>On 3/17/15 at 3:28 p.m., a policy was received from the Administrator titled "Preventative Maintenance - Inspection and Temperature Checks " indicated: Record domestic hot water temperatures at first and last room of each wing daily. Record domestic hot water temperature check at water heater.</p> <p>2. During an observation on 3/16/15 at 9:40 a.m., Room #100 was observed to have an electric pencil sharpener placed on the back of the commode and plugged into an electrical outlet. The same was observed on 3/19/15 at 7:48 a.m.</p> <p>3. During an observation on 3/16/15 at</p>			

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F 371 SS=F Bldg. 00	<p>10:19 a.m., Room 503 was observed to have an electric razor plugged into an electrical outlet and lying on the edge of the bathroom sink. The same was observed on 3/19/15 at 9:08 a.m.</p> <p>During an interview on 3/19/15 at 1:30 p.m., LPN #1 indicated electrical items should not be plugged in next to water sources.</p> <p>3.1-45(a)(1) 3.1-19(r)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to provide store, distribute, or serve food under sanitary conditions, in that, the dishwasher did not attain the correct temperature during the wash and/or rinse cycles, foods were uncovered and undated in the storage area and refrigerators, and dirt and debris were on the kitchen floor and storage area floors. This had the potential to affect 107 of</p>	F 371	<p>F371 --F-- What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Kitchen and storeroom floors were cleaned. Air conditioning unit has been relocated with pipes cleaned and grates replaced. Wall beside steam table cleaned and painted. Dish room areas painted and wall behind soiled dish area replaced. Staff in-serviced on labeling , dating and storage of food items in walk-ins</p>	04/18/2015

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	<p>110 residents.</p> <p>Findings include:</p> <p>1. During initial tour of the facility on 3/16/15 at 8:10 a.m., the floor was observed to have dirt and debris on it throughout the kitchen area and in the dry storage area. An air conditioning unit was observed beside of the free standing refrigerator with dust on the pipes and on the grate. A brown substance was observed to be dried on the wall beside the steam table, an onion peel was observed to be lying on the floor of the dry storage area. Chipped areas of paint were observed to be on the walls in the dishwasher section of the kitchen. The walk-in refrigerator had an opened bag of grapes with no date and an open bag of English muffins with no date on them. The walk-in freezer had an opened bag of beef patties with no date on them.</p> <p>The same was observed on 3/18/15 at 10:05 a.m. Also, an opened package of 2 (two) way cake mix was observed to be lying on the lower shelf in the dry storage area with no date on it and the walk-in refrigerator had an opened package of celery and an opened package of Parmesan cheese with no dates on them.</p> <p>During an interview on 3/18/15 at 11:45</p>		<p>and storage room. Opened items in walk-ins and storeroom thrown away. Dishwasher , electrical board, and gasket replaced. Electrical wire repaired. Dietary staff in-serviced on 3/17/15 on appropriate wash and rinse temperatures of dish machine and action to take if temps are not appropriate.</p> <p>--How will other residents who may have the potential to be affected be identified? All dietary staff will be in-serviced/educated on appropriate wash and rinse temperatures of the dish machine and action to take if temps are not appropriate by 4/10/2015. All dining staff will be in-serviced on dating , labeling and storage of items by 4/10/15 . Dishwasher, electrical board, and gasket replaced. Electrical wire repaired. Dishwasher temps will be recorded 3x a day prior to ware washing.</p> <p>-- What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. Dining services manager or designee will monitor the dishwasher temperature log for completion and accuracy daily. Sanitation audit will be completed bi-weekly by the Registered Dietitian, Executive Director or designee x2 months and then monthly thereafter. Dietary cleaning schedule and dish machine</p>				

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	<p>a.m., the Adm (Administrator) indicated the kitchen received a thorough cleaning quarterly by the housekeeping department and the dietary staff was responsible for the cleaning daily. The Adm indicated the dietary staff had a schedule for cleaning but she did not see it in the kitchen.</p> <p>During an interview on 3/19/15 at 12:15 p.m., the Adm indicated the DM (Dietary Manager) had removed the undated foods from the walk-in refrigerator.</p> <p>2. During the initial tour of the kitchen on 3/16/15 at 8:10 a.m., the water temperature of the wash cycle was observed to attain a temperature of 155 degrees F (Fahrenheit) but the rinse cycle only attained 172 degrees F. The dishwasher had a manufacturer's label on it which indicated the wash cycle was to be at 150 degrees F and the rinse cycle should reach 180 degrees F.</p> <p>During an interview on 3/16/15 at 0813, the DSP (dietary service person) #1 indicated the dishwasher needed to cycle 5-6 times before the rinse cycle would reach 180 degrees F. DSP #1 indicated the dietary staff should notify maintenance if the dishwasher did not reach the proper temperatures.</p>		<p>logs will be monitored by the DSM or designee using the monitoring tool 5x per week for 4 weeks and then 3x per week for 4 weeks and then weekly thereafter.</p> <p>--How will the corrective action(s) be monitored to ensure the deficient practice will not recur and what QA program will be put into place? Findings will be reported in QAPI monthly x6 months unless additional monitoring is deemed necessary at that time.</p> <p>--Systematic changes will be completed by: <u>April 18, 2015</u> <u>**We are requesting paper compliance for F371</u></p>	

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	<p>During an interview on 3/16/15 at 9:00 a.m., the Dietary Manager (DM) indicated the dishwasher rinse cycle was not working properly and the dishwasher needed to be used for several times before it would reach the correct temperature. The DM indicated maintenance was aware of the problem and a part had been ordered. Upon further query, the DM indicated the part was not ordered until this morning.</p> <p>During an interview on 3/16/15 at 10:55 a.m., the Adm (Administrator) indicated maintenance had worked on the dishwasher and the dietary staff could use it as the temperature would reach above 180 degrees F. The Adm indicated the dietary staff would be maintaining a log of the rinse cycle temperatures until the dishwasher parts arrived and the dishwasher was correctly repaired.</p> <p>3. During an observation of the kitchen on 3/18/15 at 10:10 a.m., the dishwasher was observed for 2 separate cycles to attain a wash temperature of 130 degrees F. The rinse temperature reached 186 degrees F.</p> <p>During an interview on 3/18/15 at 10:15 a.m., the DM (Dietary Manager) indicated the dishwasher had not been</p>			

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	<p>reaching 150 degrees since 3/17/15.</p> <p>During an interview on 3/18/15 at 10:23 a.m., the Adm indicated the facility would be using paper items until the dishwasher was completely repaired. The Adm indicated the non-disposable items would be washed and rinsed in the 3-compartment sink. The Adm further indicated a wire had burned in the dishwasher and the board was out.</p> <p>4. A log, dated March, 2015, and obtained from the Adm (Administrator) on 3/16/15 at 3:45 p.m., indicated the temperatures were to be obtained in the morning, at noon, and in the p.m. (evening) times. The following dates were not documented: 3/2/15 at noon 3/4/15 in the a.m. or noon time 3/5/15 at noon or in the p.m. 3/7/15 at noon 3/8/15 in the a.m. or at noon time 3/9/15 for the a.m., noon, or p.m. times 3/11/15 at the p.m. time 3/14/15 at the noon or p.m. times 3/15/15 at the p.m. times.</p> <p>The log further indicated the dishwasher had the following temperatures for the wash cycle: 3/1/15 at 6:00 a.m.: 145 degrees F</p>			

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F 465 SS=F Bldg. 00	<p>3/1/15 at 12:20 p.m.: 142 degrees F 3/2/15 at 8:00 a.m.: 145 degrees F 3/3/15 at a.m. time.: 142 degrees F 3/3/15 at 12:00 noon: 142 degrees F 3/6/15 at 12:00 noon: 143 degrees F 3/6/15 at 4:30 p.m.: 146 degrees F 3/8/15 at 4:00 p.m.: 140 degrees F 3/10/15 at 12:00 noon: 143 degrees F 3/12/15 at 4:20 p.m.: 140 degrees F 3/13/15 at 5:30 p.m.: 147 degrees F.</p> <p>A policy, obtained from the Adm on 3/19/15 at 11:45 a.m., indicated the dishwasher machine temperature for the wash cycle must be maintained at a minimum of 150 degrees F per state regulations during a wash cycle time of 40 seconds. The policy indicated the temperature should not exceed 175 degrees F. The policy indicated for the rinse cycle the temperature must be maintained at a minimum of 180 degrees F per gauge with the rinse cycle time of 9 seconds. The policy further indicated the temperature should not exceed 194 degrees F.</p> <p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for</p>			

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	<p>residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe, secure, and sanitary environment for the residents and/or families in 22 of 33 rooms, in that, floors were soiled with trash, dirt, and debris, trash was overflowing, a fall mattress was soiled, resident care items were uncovered and unlabeled, commodes were soiled, and heating/air conditioning units were soiled and had covers off of them. (Room 100, Room 109, Room 110, Room 113, Room 205, Room 207, Room 301, Room 303, Room 306, Room 401, Room 404, Room 405, Room 406, Room 501, Room 502, Room 503, Room 504, Room 505, Room 507, Room 509, Room 601, Room 603)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 3/16/15 at 9:40 a.m., Room #100 was observed with dirt and debris on the edges of the bathroom floor. The same was observed on 3/19/15 at 7:48 a.m. as well as, the commode rim was dirty with a brown substance and a wadded up piece of paper were observed under the bed. 2. During an observation on 3/17/15 at 9:17 a.m., Room #109 was observed to have 2 (two) uncovered and unlabeled 	F 465	<p>F465</p> <p>--F-- What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>All resident rooms and resident bathrooms cited will be stripped and waxed, concentrating on corners and edges. All rooms cited will be completed by 4/10/2015 and all other resident rooms will also be stripped and waxed at a rate of 6-8 rooms every week.</p> <p>Housekeeping staff were in-serviced on daily cleaning of rooms and bathrooms on April 3, 2015. All rooms were inspected for proper storage and labeling of personal care items. Nursing staff were in-serviced on storage and labeling of personal care items by 4/10/15.</p> <p>Room 301 and 501 heater grates were cleaned of debris and had covers replaced.</p> <p>Room 404 wall board has been repaired.</p> <p>Room 501 bathroom door has been repainted.</p> <p>Room 502-A mat beside bed was deep cleaned.</p> <p>Room 503 over the bed table had velcro and adhesive residue removed.</p> <p>Room 504 door handle cover to bathroom door was tightened.</p> <p>Room 505 Bathroom faucet has been repaired</p> <p>Room 509 Bathroom sink drain repaired.</p>	04/18/2015			

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	<p>urine collection containers on the floor. The bathroom and bedroom floors had dirt and debris build-up in the corners and along the edges of the cove base. The same was observed on 3/19/15 at 7:50 a.m.</p> <p>3. During an observation on 3/17/15 at 9:17 a.m., Room #110 was observed to have a denture cup in the bathroom with no name on it and dirt and debris was observed to be built-up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 7:54 a.m., as well as, a dirty napkin was observed on the floor under the bed. The bathroom was shared with 3 (three) other residents.</p> <p>4. During an observation on 3/16/15 at 3:42 p.m., Room #113 was observed to have dirt and debris built up in the corners and around the edges of the floor. The same was observed on 3/19/15 at 7:55 a.m.</p> <p>5. During an observation on 3/17/15 at 3:42 p.m., Room #205 was observed to have dirt and debris built up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 8:02 a.m.</p> <p>6. During an observation on 3/16/15 at 11:18 a.m., Room #207 was observed to</p>		<p>Room 601& 603 Vent fans in the bathrooms were replaced. --How will other residents who may have the potential to be affected be identified? All resident rooms and bathrooms will be stripped and waxed, concentrating on corners and edges at a rate of 6-8 rooms per week. Housekeeping staff have been in-serviced on daily cleaning of rooms and bathrooms on 4/3/2015 Nursing staff were in-serviced on storage and labeling of personal care items by 4/10/2015 -- What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. All rooms and bathrooms will be cleaned daily by housekeeping staff. 1x a month the room and bathroom will be deep cleaned, concentrating on corners and edges. Housekeeping supervisor will complete an inspection daily on 3 rooms per day, 5 days per week. Guardian angel staff will inspect rooms for soiled floors/bathrooms, storage and labeling of personal care items and any maintenance concerns that need attention daily, 5 x per week. Findings will be recorded on the guardian angel rounds sheet. Sheets are reviewed by Executive Director or designee 5x per week with any housekeeping/maintenance concerns reported to those department directors for correction/repair. --How will the corrective</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630		
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	<p>have dirt and debris built up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 8:06 a.m.</p> <p>7. During an observation on 3/16/15 at 2:47 p.m., Room #301 was observed to have dirt and debris built up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 7:57 a.m., as well as, dirt and debris was observed on the filter of the heating/air conditioning unit.</p> <p>8. During an observation on 3/17/15 at 10:46 a.m., Room #303 had dirt and debris built up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 7:59 a.m.</p> <p>9. During an observation on 3/17/15 at 9:09 a.m., Room #306 was observed to have 2 unlabeled denture cups and an unlabeled battery powered toothbrush in a coffee cup in the bathroom. Dirt and debris were built up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 8:00 a.m., as well as, the room floor was marred with black marks. The bathroom was shared with 3 other residents.</p> <p>10. During an observation on 3/17/15 at 8:16 a.m., Room #401 was observed to</p>		<p>action(s) be monitored to ensure the deficient practice will not recur and what QA program will be put into place? All findings will be reported in QAPI monthly x6 months unless additional monitoring is deemed necessary.</p> <p>--Systematic changes will be completed by: <u>April 18, 2015</u> **<u>We are requesting paper compliance for F465</u></p>		

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	<p>have dirt and debris built up in the corners and along the edges of the floor and a brownish-yellow stain around the base of the commode. The same was observed on 3/19/15 at 8:29 a.m., as well as, the bathroom floor was sticky and had a black stain in front of the commode.</p> <p>11. During an observation on 3/16/15 at 9:35 a.m., Room #404 had an opened packages of briefs in the bathroom floor and wallboard was chipped off the bedroom wall. During an observation on 3/19/15 at 8:35 a.m., the trash was overflowing in the trash can, graham crackers and pieces of paper trash were observed on the floor and there was a brown stain around the base of the commode.</p> <p>12. During an observation on 3/16/15 at 2:52 p.m., Room #405 was observed to have dirt and debris built up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 8:32 a.m., as well as, a brown stain was observed around the base of the commode.</p> <p>13. During an observation on 3/16/15 at 9:59 a.m., Room #406 was observed to have a black stain upon entering the bedroom floor and there was dirt and debris built up in the corners and the</p>			

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	<p>edges of the floor. The same was observed on 3/19/15 at 8:58 a.m.</p> <p>14. During an observation on 3/16/15 at 10:04 a.m., Room #501 was observed to have the cover of the heating/air conditioning unit missing, the bathroom door had chipped paint, and dirt and debris was built up in the corners and along the edges of the floor. The same was observed on 3/19/15 at 9:01 a.m., as well as, debris was observed on the heating/air conditioning unit filter.</p> <p>15. During an observation on 3/16/15 at 3:35 p.m., Room #502 was observed to have an inflated "EZ Shampoo" apparatus on the floor under the sink in the bathroom, a mattress beside Room #502 A's bed was soiled with dirty footprints and dirt and debris built up in the corners and the edges of the floor. The same was observed on 3/19/15 at 9:05 a.m., as well as, paper trash was observed under the overbed table of Room 502 A. The bathroom was shared by 2 (two) residents.</p> <p>16. During an observation on 3/16/15 at 10:19 a.m., Room #503 was observed to have an unlabeled urinal on the back of the commode hanging on the arm rail and dirt and debris were built up in the corners and along the edges of the floor.</p>			

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	<p>A soiled glove was observed to be on the floor in the room and a black Velcro strip located on Room 503 A's overbed table was soiled. The same was observed on 3/19/15 at 9:08 a.m., except, the glove was removed and the black Velcro strip had been replaced with 2 white Velcro strips which were soiled. The bathroom was shared by 2 (two) residents.</p> <p>17. During an observation on 3/16/15 at 10:40 a.m., Room #504 was observed to have dirt and debris built up in the corners and along the edges of the floor and furniture (a high back chair, a regular chair, a wheelchair, and a walker) was stored in front of Room 504 B's bed which was occupied. The same was observed on 3/19/15 at 9:10 a.m. except the furniture had been removed and the door handle cover to the bathroom door was loose.</p> <p>18. During an observation on 3/16/15 at 10:57 a.m., Room #505's bathroom was observed to have water spewing out whenever the sink faucet water was turned on. The same was observed on 3/19/15 at 9:11 a.m., as well as, the commode extender had a brown substance on it.</p>			

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	<p>19. During an observation on 3/16/15 at 9:44 a.m., Room #507 was observed to have dirt and debris built up in the corners, around the door frames, and in the edges of the floor. The same was observed on 3/19/15 at 9:13 a.m.</p> <p>20. During an observation on 3/16/15 at 3:22 p.m., Room #509 was observed to have the bathroom sink draining slowly. The same was observed on 3/19/15 at 9:15 a.m., as well as, there was dirt and debris built up in the corners and along the edges of the room.</p> <p>21. During an observation on 3/16/15 at 1049, Room #601 was observed to have the bathroom vent fan with a loud noise when turned on. The same was observed on 3/19/15 at 9:18 a.m.</p> <p>22. During an observation on 3/16/15 at 10:53 a.m., Room #603 was observed to have the bathroom vent fan with a loud noise when turned on. The same was observed on 3/19/15 at 9:20 a.m.</p> <p>During an interview on 3/16/15 at 3:38</p>			

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F 500 SS=D Bldg. 00	<p>p.m., Maintenance Man #2 indicated he had a lot of work to do after checking the water faucet and sink in rooms 505 and 509.</p> <p>During an interview with Housekeeper #1 on 3/19/15 at 8:53 a.m., Housekeeper #1 indicated if a room had chipped paint or loud vent fans, maintenance would be notified. Housekeeper #1 further indicated rooms are deep cleaned once a month on a rotating schedule and the schedule is kept on each housekeeper's cart.</p> <p>During an interview on 3/19/15 at 2:35 p.m., the Housekeeping Manager indicated she knew the floors were dirty. She indicated the floors were replaced last year but they were difficult to keep clean.</p> <p>3.1-19(f)</p> <p>483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to</p>			

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	<p>residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section.</p> <p>Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.</p> <p>Based on interview and record review, the facility failed to provide a written agreement for 1 of 4 residents reviewed for dialysis, in that, the facility did not have a contract with the outside dialysis unit. (Resident #25)</p> <p>Findings include:</p> <p>During an observation on 3/18/15 at 8:10 a.m., Resident #25 was observed to be sitting in her room in a wheelchair. Resident #25 was observed to have a bandage on her right upper arm. Resident #25 indicated she had a graft and received dialysis on Monday, Wednesday, and Friday each week. Resident #25 indicated she received dialysis at a free standing dialysis center.</p> <p>The clinical record of Resident #25 was reviewed on 3/18/15 at 8:27 a.m.</p>	F 500	<p>F500 --F-- What corrective action will be accomplished for those residents found to have been affected by the deficient practice. A contract with the outside dialysis center will be obtained. --How will other residents who may have the potential to be affected be identified? A contract with the outside dialysis center will be obtained by 4/18/15. -- What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. The contract was written to automatically renew each year and will be reviewed annually. --How will the corrective action(s) be monitored to ensure the deficient practice will not recur and what QA program will be put into place? Contract will automatically renew each year. QA will review dialysis contracts yearly for any needed changes. --Systematic changes will be</p>	04/18/2015

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	<p>Resident #25 had diagnoses including, but not limited to, end stage renal disease, depressive disorder, restless leg syndrome, insomnia, and vitamin D deficiency. The admission MDS (Minimum Data Set) assessment, dated 1/15/15, indicated Resident #25 had slight cognitive impairment.</p> <p>A physician's order, dated 1/20/15 and signed on 2/18/15, indicated Resident #25 was to receive dialysis on Monday, Wednesday, and Friday.</p> <p>During an interview on 3/18/15 at 8:48 a.m., the Adm (Administrator) indicated the facility did not have a contract with the dialysis center for the resident's dialysis services. The Adm indicated she had been attempting to obtain a contract from her corporate office since December, 2014, but the facility had not been able to obtain one yet.</p> <p>3.1-13(m)(1)</p>		<p>completed by: <u>April 18, 2015</u> <u>**We are requesting paper compliance for F500</u></p>		