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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/20/2014 |
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| NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF | STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 16, 17, 18, 19, 20, 2014</p> <p>Facility number: 000036 Provider number :155093 AIM number: 100269640</p> <p>Survey team: Denise Schwandner, TC Barbara Fowler ,RN Diane Hancock, RN 2/16, 2/17, 2/18, 2/19/14 Diana Perry, RN Anna Villans, RN Sylvia Martin, RN</p> <p>Census bed type: SNF/NF 39 Total 39</p> <p>Census payor type: Medicare 5 Medicaid 27 Other 7 Total 39</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> | F000000 | The SNF requests that the following plan of correction be considered its credible allegation of compliance. The SNF respectfully requests that a post-certification desk review, rather than a post-certification onsite visit, occur to verify compliance. | |

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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| F000241 SS=D | <p>Quality review completed on February 26, 2014, by Jodi Meyer, RN</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were treated in a dignified manner, in that, a resident was assisted with a meal while staff was standing over the resident and activity staff discussed scheduling needs during activities and did not interact with the residents for 3 of 7 residents reviewed. (Resident # 59, #30 and one unidentified resident)</p> <p>Findings include:</p> <p>1. On 2/16/14 at 5:15 p.m., observed CNA #2 attempting to assist an unidentified resident during the evening meal, while standing over resident.</p> | | | F000241 | <p>Residents #59 and #30 did not have any adverse effect. It was determined that all residents have the potential to be affected. The following measures were taken or will be taken: 25 of 37 residents were considered alert and oriented by the care plan team on 3-6-14. 25 residents were interviewed 3-6-14 and asked by Social Services if they were treated with dignity and respect at all times. 25 of 25 responded that they were treated with dignity and respect at all times. Small group training for SNF staff by the Director of Nursing (DON) began 3-5-14 and will be completed with 3 exceptions on 3-11-14. Exceptions will each receive 1:1 training from the DON by 3-17-14. Training focuses are 1) staff must be seated when feeding a resident; 2) conversation in common resident areas and in presence of a resident must be</p> | | 03/17/2014 |

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| | On 2/20/14 at 8:51 a.m., the DoN (Director of Nursing) provided the "Dining Room Service-SNF" policy. The policy indicated, "If a resident requires assistance to eat their meal, seat yourself beside that resident in order to assist them so you are eye level with them. Avoid standing over them during the time you are assisting them with eating". | | resident-focused; and 3) care must be provided in a manner that enhances each resident's dignity and respect in full recognition of his or her individuality. Resident Right education is a monthly resident group activity. For March, the focus will be on the right to receive care in a manner and environment that enhances each resident's dignity and respect in full recognition of his or her individuality. This activity will be conducted by the Activity Director and will take place on 3-13-14. To monitor and prevent recurrence the following will occur: New SNF nursing employee orientation will include the importance and expectation of dignity and respect of individuality. This will begin 3-12-14. Resident dining and group activities will be monitored by nurses, social services and the SNF administrator to assure: 1) staff do not stand and feed, and 2) conversation in resident common areas and in presence of a resident must be resident-focused (see attachment 2202014 Dining). Monitoring will occur at least 4 times per week for 30 days and at least weekly after that. Observation results and actions taken will be summarized to the Skilled Nursing Facility Performance Improvement Committee (SNF PIC) for at least one year. The SNF PIC will monitor for compliance and will make recommendations as | | |

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| | <p>2. On 2/18/14 at 9:10 a.m., during an observation of activities Act #1 and Act #2 were observed providing nail care for Resident #59 and Resident #30. During that activity staff was observed to be discussing scheduling needs, neither staff members were interacting with residents.</p> <p>The Administrator was interviewed on 2/20/14 at 11:00 a.m. He indicated the activities staff was aware they should have interacted with the residents during activities.</p> <p>3.1-3(t)</p> | | needed. | | |

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| F000272 SS=D | <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to provide an accurate MDS (Minimum Data Set) assessment for 1 of 3</p> | F000272 | The care plan team reviewed resident #25. The plan of care for resident #25 was updated 2-28-14 to reflect a preference for wearing pajamas during the day. Resident #25 MDS was updated | 03/21/2014 |

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| | <p>residents reviewed for dressing and 1 of 6 residents reviewed for dental status in a sample of 26 residents whose MDS assessments were reviewed, in that, the residents were incorrectly assessed for ADLs (Activities of Daily Living) and dental status. (Resident #25, Resident #12)</p> <p>Findings include:</p> <p>1. During an observation on 2/17/14 at 9:00 a.m., Resident #25 was observed to be lying in bed with her pajamas on.</p> <p>During an observation on 2/17/14 at 11:20 a.m., Resident #25 was observed to be sitting in a wheelchair with her pajamas on. Resident #25 indicated she baths and dresses herself.</p> <p>During an observation on 2/18/14 at 10:00 a.m., Resident #25 was observed to be sitting in a wheelchair with pajamas on.</p> <p>The clinical record for Resident #25 was reviewed on 2/18/14 at 1:25 p.m. Resident #25 had diagnoses including, but not limited to, anemia, anxiety, depression, and generalized weakness. A MDS assessment,</p> | | <p>3-6-14 and reflects that she is independent in regards to dressing. Resident #25 BIMS was updated 3-6-14 and reflects mild cognitive loss. Resident #12 dental needs and history were reviewed by the care plan team. Resident #12 admission assessment reflects she admitted with upper and lower dentures on 10-4-13. On 2-13-14 the dentures were in place at breakfast and lowers were reported missing at lunch. A search ensued with no results. The resident saw her dentist of choice on 2-19-14. A denture mold was taken to start the replacement process. There has been no adverse affect. As a temporary intervention, resident #12 was placed on a mechanical soft diet on 2-14-14. The MDS nurse and Social Services verified on 3-6-14 that Resident #12 plan of care is reflective in these regards. It was determined that all residents have the potential to be affected. The following measures have or will be taken: The MDS nurse will be responsible to coordinate the creation of an initial roster for dressing ability and an initial roster for dental needs. The MDS and admission assessments will be used to create the initial rosters. A team that will include care plan team members and nurse aides will review the rosters before they are approved by the DON. The team will identify and address any discrepancies to assure that the</p> | | | | |

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| | <p>dated 12/9/13, indicated Resident #25 had a BIMS (Brief Interview for Mental Status) assessment score indicating slight cognitive impairment. The MDS further indicated Resident #25 needed limited assistance of 1 (one) person for dressing.</p> <p>During an interview on 2/17/14 at 11:20 a.m., Resident #25 indicated she did not require any assistance with dressing.</p> <p>During an interview on 2/18/14 at 11:25 a.m., LPN #1 indicated Resident #25 was able to dress herself. LPN #1 further indicated Resident #25 preferred to wear her pajamas during the day but occasionally Resident #25 would wear regular clothing.</p> <p>During an interview on 2/18/14 at 11:30 a.m., CNA #1 indicated Resident #25 did not require assistance with dressing.</p> <p>During an interview on 2/19/14 at 2:45 p.m., the MDS Coordinator indicated Resident #25 would dress herself and did not require assistance.</p> <p>2. During an observation on 2/17/14</p> | | <p>rosters are accurate and reflective. These initial rosters will be created by 3-21-14. To monitor and prevent future recurrences, the following will occur: The DON or her designee will train nursing staff and the care plan team of the need to communicate changes in dressing ability and dental needs to one another. This training will be done in small groups. This training will begin 3-17-14 and will be completed by 3-21-14. As part of the training the DON will introduce a Resident Observation Notification (RON) (see attachment 2202014 Resident Observation). The RON will serve as a tool for staff to communicate observations of resident needs or changes related to ADLs (such as dressing) or medically related social services (such as dentures). Staff will be instructed to forward completed RON to the MDS Nurse. The MDS Nurse will log receipt of the form, notify the appropriate discipline, and assure follow-up. The MDS Nurse will be responsible to coordinate updating of the initial rosters for dressing ability and dental needs quarterly. Team review will continue to precede DON approval of the updated rosters. The MDS Nurse and Social Services will work cooperatively to keep the rosters current. This will be done by recording changes as they are reported or noted via RON or other means. This</p> | | | | |

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| | <p>at 11:02 a.m., Resident #12 was observed to be sitting in a chair in her room with her upper dentures missing.</p> <p>The clinical record for Resident #12 was reviewed on 2/18/14 at 11:00 a.m. Resident #12 had a diagnosis including, but not limited to, dementia. A MDS (Minimum Data Set) assessment, dated 10/28/13, indicated Resident #25 did not have any dental issues.</p> <p>During an interview on 2/17/14 at 11:03 a.m., Resident #12's spouse indicated Resident #12 had full upper and lower dentures. Resident #12's spouse indicated the resident was edentulous. Resident #12's spouse further indicated the resident had a dental appointment on 2/19/14 as her upper dentures were missing.</p> <p>During an interview on 2/18/14 at 9:34 a.m., the SSD (Social Services Designee) indicated Resident #12 had lost her dentures last week. The SSD indicated the resident had a dental appointment on 2/19/14.</p> <p>During an interview on 2/19/14 at 11:35 a.m., LPN #2 indicated Resident #12 was edentulous as</p> | | <p>process, along with any challenges, will be summarized by the DON and MDS Nurse to the SNF PIC for at least one year. The SNF PIC will monitor for compliance and will make recommendations as necessary.</p> | | | | |

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| | <p>she had upper and lower dentures. LPN #12 indicated when a resident is admitted to the facility, the nursing staff would document on an admission form regarding any issues a resident might have. The admission documentation indicated Resident #12 had upper and lower dentures.</p> <p>During an interview on 2/19/14 at 11:40 a.m., CNA #1 indicated Resident #12 did not have any teeth when she was admitted to the facility. CNA #1 indicated Resident #12 had a full set of upper and lower dentures.</p> <p>During an interview on 2/19/14 at 11:45 a.m., the MDS coordinator indicated she would obtain information from the CNA flow sheet and interview the staff prior to entering the MDS assessment information.</p> <p>The facility provided a policy with dates for the MDS assessments of the residents but no policy was provided for assessment of the residents for the MDS assessment.</p> <p>3.1- 31(c)(1)</p> | | | | |

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| F000329 SS=D | <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 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 observation, record review, and interview, the facility failed to ensure 1 of 1 residents</p> | F000329 | Pharmacy recommendations for resident #34 were reviewed. On 4-25-13 the pharmacist made a recommendation regarding resident #34 and Zoloft. On | 03/21/2014 | |

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| | <p>were free of potentially unnecessary medications, in that gradual dose reductions were not attempted in the absence of behavioral symptoms. (Resident #34)</p> <p>Finding includes:</p> <p>Resident #34's clinical record was reviewed on 2/18/14 at 10:25 a.m. The resident was admitted to the facility on 11/15/10 with diagnoses including, but not limited to, history of subdural hematoma, dementia, fibromyalgia, gastroesophageal reflux disease, hypertension, arthritis, Alzheimer's disease, and diabetes mellitus.</p> <p>Resident #34's quarterly Minimum Data Set (MDS) assessment, dated 1/14/14, indicated short and long term memory problems and severe impairment of decision-making. The MDS indicated the resident was on antipsychotic medication, antidepressant medication, and hypnotic medication. A behavior identified was wandering in the past 1-3 days.</p> <p>Physician's orders, signed 1/26/14, included, but were not limited to, the following: Zolpidem (Ambien, sleep</p> | | <p>5-2-13 the physician responded he disagreed. On 8-27-13 and 11-27-13 the pharmacist made recommendations regarding resident #34 and Ambien On 8-22-13 and 12-13-13 the physician responded that he disagreed, On 10-24-13 the pharmacist made a recommendation regarding resident #34 and Seroquel. On 11-12-13 the physician responded that he disagreed. On 1-28-14 the pharmacist made a recommendation regarding resident #34 and Elavil. On 2-20-14 an order was received from the physician to discontinue Elavil for resident #34. The following corrective action was taken: On 3-11-14 the pharmacist made a recommendation regarding Zolofit and resident #34 and it was forwarded to the physician. It was determined that all residents have the potential to be affected. The following measures will be taken: the DON will coordinate a review of all individual pharmacist recommendations since 9-1-13. The review will identify any recommendations that were declined or did not receive a response. Declined recommendations will be logged and the DON will work cooperatively with the pharmacist to assure that declined recommendations are reviewed and reassessed by the pharmacist in 6 months or less.</p> | | | | |

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| | <p>medication) 5 milligrams one by mouth at bedtime since 8/23/13 Sertraline hydrochloride (Zoloft, antidepressant) 100 milligrams one by mouth daily since 5/21/13 Amitriptyline (Elavil, antidepressant medication) 25 milligrams one by mouth daily at bedtime since prior to 1/31/13 Seroquel (antipsychotic medication) 50 milligrams by mouth daily at 1400 (2:00 p.m.) since 4/2/13 Seroquel 50 milligrams by mouth at bedtime since 4/2/13</p> <p>The resident had a care plan, dated 7/22/13, for being at risk for side effects to Seroquel, Ambien, Elavil, and Zoloft. Interventions included, but were not limited to, "Reassess q (every) 6 mos (months) and prn (as needed) for possible reduction and continued use."</p> <p>The record included a psychotropic medication quarterly evaluation, dated 1/14/14. It included the following medications being reviewed, Elavil, Zoloft, Ambien, and Seroquel. Diagnoses documented were dementia with behaviors, Alzheimer's disease, and depression. The evaluation form included information on the behavior warranting the use of the</p> | | <p>This review will be completed by 3-21-14. Actions taken will be summarized by the DON and reported to the SNF PIC. The DON or her designee will be responsible to: 1) resubmit any individual pharmacy recommendations that do not receive a response from the physician within 21 calendar days and to do so within 3 business days, and 2) assure that all individual pharmacy recommendations are forwarded to the physician within 3 business days of being received by the SNF. To monitor and prevent recurrence the following will occur: The DON or her designee will keep an ongoing log of individual pharmacy recommendations to assure (see attachment 2202014 Pharmcy) : 1) physician non-responses result in a timely reminder; 2) declined recommendations are reassessed by the pharmacist at least every 6 months, and 3) all individual pharmacy recommendations are forwarded in a timely manner to the physician. The DON will summarize this process and any associated challenges to the SNF PIC for at least one year. The SNF PIC will monitor for compliance and will make recommendations as necessary.</p> | | | | |

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| | <p>medication. This section was blank. No behaviors were listed.</p> <p>Recommendations were made by the pharmacist for gradual dose reductions on the following dates: Elavil 1/28/14 Ambien 8/23/13, 12/13/13 Seroquel 10/24/13</p> <p>Social Services notes, dated 1/14/14, included, but not limited to, the following: "...She wheels around this place full of energy most days. She dos not express negative remarks or sadness. She does seem more lethargic and slower to move and react today - some days she is fidgety and we can't keep her in one place..."</p> <p>The Social Services employee was interviewed on 2/19/14 at 11:00 a.m. She indicated the resident didn't really have any behaviors. They had to watch if she was wandering the halls. She attempted to get up without assistance, setting off her alarms. Otherwise, nothing. The pharmacist recommended decreasing medications, but the physician had not made any changes.</p> | | | | | | |

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| F000371 SS=F | <p>The Director of Nursing was interviewed on 2/19/14 at 11:05 a.m. She indicated they were not tracking any behaviors for the resident. She indicated the pharmacist had made recommendations for reductions, but the physician had not approved them.</p> <p>The facility provided a policy for pharmacy recommendations but no policy was provided by the facility in the absence of physician approval.</p> <p>3.1-48(b)(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 Based on observation, interview, and record review, the facility failed to ensure food was properly stored and distributed in a sanitary mannner, in that, trash cans were not properly covered, food products were not labeled with open dates,</p> | F000371 | The following immediate steps were taken: 1 and 13) the manager on duty reminded staff that inactive trash cans must be lidded; 4 and 12) lasagna was disposed of on 2-19-14 per direction of the Food Service Director; 5 and 11) the freezer floor was cleaned and corners | 03/14/2014 |

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| | <p>food products were not sealed, food products were stored on the floor, the freezer was unclean, and straws were distributed unsanitarly in 1 of 1 kitchens potentially affecting 39 residents who ate at the facility.</p> <p>Findings include:</p> <p>On 2/16/14 at 3:41 p.m., the following was observed in the kitchen:</p> <ol style="list-style-type: none"> Two trash cans with no lids in place. An opened bag of cheese in the cooler with no open date present. A bowl of labeled vegetable soup partially covered with the plastic wrap covering torn. An pan of frozen lasagna with the lid not covering the entire package. Food debris built up in the right corner of the freezer. A thermometer not present in the freezer. An opened bag of chicken flavored stuffing mix with no open date. | | <p>were checked for debris by the manager; 6) two thermometers were in the freezer at the time of inspection. Staff were instructed on proper placement of the thermometers in the freezer for easy accessibility. 10) the fish was covered on 2-16-14. On 2-19-14 the fish was located on the wrong thawing shelf in the cooler prior to being utilized. The Food Service Director met with all cooks on 2-20-14, after being informed of the surveyor observations, and education occurred. Additionally, all staff were inserviced by dietary supervisors on 3/2/14 and 3/8/14 regarding proper storage of meat products in the cooler. All other observations were communicated to the SNF and kitchen post-survey. These observations were used to develop and enhance staff education. The following measures have or will be taken to prevent recurrence: The kitchen's sanitation is monitored by managers throughout each day. Concerns that are identified get immediate attention. A review of sanitation findings and training related to these findings was communicated to all dietary staff by the Food Service Director. This small group training began 3-7-14 and will be completed with 2 exceptions on 3-9-14. The exceptions will have 1:1 training by 3-19-14. Training topics included but were not exclusive to: trash cans, date marking, food storage,</p> | | |

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| | <p>8. A can of chicken noodle soup stored on the floor.</p> <p>9. An open can of Mountain Dew next to uncovered muffins on a food preparation table.</p> <p>On 2/16/14 at 5:01 p.m., LPN #4 was randomly observed to handle a drinking straw without the paper barrier in place, and place the straw in an unidentified resident's drinking glass.</p> <p>On 2/16/14 at 5:03 p.m., CNA #2 was randomly observed to handle a drinking straw without the paper barrier in place, and place the staw in an unidentified resident's drinking glass.</p> <p>On 2/19/14 at 8:17 a.m., the following was observed in the kitchen:</p> <p>10. Uncovered fish thawing on a shelf in the cooler.</p> <p>11. Food debris built up in the right corner of the freezer.</p> <p>12. A pan of frozen lasagna with the lid not covering the entire package as well as other pans of frozen</p> | | <p>sweeping/mopping, wet cloths, thermometers, and personal beverages. All nursing staff received small group training from the DON with return demonstration regarding the proper way to place a straw beginning 3-5-14. This training will be completed with 3 exceptions on 3-11-14. The exceptions will receive 1:1 training by 3-17-14. To prevent future recurrence the following will occur: All new nursing staff will have proper straw placement addressed in their department orientation. All new dietary staff will continue to have sanitation expectations defined for them in their department orientation. The Food Service Director will summarize sanitation findings and report them to the SNF PIC for at least one year. The SNF PIC will make recommendations as necessary and will assist as needed in monitoring compliance. Resident dining will be monitored by nurses and the SNF administrator to assure that straws are placed properly. Monitoring will occur at least 4 times per week for 30 days and then at least weekly. Observation results and any challenges will be summarized and reported by the DON to the SNF PIC for at least one year. The SNF PIC will monitor for compliance and will make recommendations as necessary.</p> | | |

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| | <p>lasagna stacked on top of inadequately covered lasagna.</p> <p>13. Two trash cans with no lids in place.</p> <p>14. A can of chicken noodle soup stored on the floor.</p> <p>15. A package of bread not sealed.</p> <p>16. A wet cloth laying on the counter under the coffee machine.</p> <p>On 2/19/14 at 1:22 p.m., the Food Service Director was interviewed. The Food Service Director indicated coolers and freezers are swept daily. The Food Service Director further indicated cooler and freezer temperatures are checked and recorded daily.</p> <p>On 2/19/14 at 1:38 p.m., the Food Service Director provided the "Food Storage" policy. The policy indicated, "Food items will be stored on shelves or can carts, with heavier and bulkier items stored on lower shelves. Nothing is stored directly on the floor...All containers must be sealed to prevent possible pest contamination and preserve food quality...". The policy further indicated, "All foods should be</p> | | | | |

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| F000465 SS=E | <p>covered, labeled and dated...".</p> <p>On 2/19/14 at 2:02 p.m., CNA #3 was interviewed. CNA #3 indicated drinking straws should not directly be handled without gloves or without the paper barrier in place.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and policy review the facility failed to provide a sanitary environment, in that removable dirt was built up in doorways of 14 of 22 rooms reviewed and white build up was present on 8 out of 10 resident bathrooms reviewed for the environment. (Rooms 5511, 5513, 5515, 5517, 5519, 5521, 5523, 5525, 5527, 5529, 5533, 5525, 5537)</p> | F000465 | <p>Immediate steps were taken: The wheelchair outside room 5519 was cleaned on 2-19-14 by the assigned C.N.A. The floor leading into room 5519 was cleaned by the Housekeeping Manager on 2-19-14. Training in small groups for all SNF housekeepers began on 3-9-14 regarding cleaning/santizing and other Area Assignment expectations. This training is a responsibility of the Housekeeping Manager and will be completed by 3-13-14. The Housekeeping Manager and SNF Administrator assessed floor status of the following rooms on 2-28-14: 5511, 5513, 5515, 5517,</p> | 03/22/2014 | | | |

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| | <p>Findings include:</p> <p>1. During observation of the halls on the skilled unit on 2/18/14 at 9:50 a.m., 2/18/14 at 3:00 p.m, 2/19/14 at 9:00 a.m., the following rooms were observed to have removable debris in corners of the doorways visible when the doors were opened and closed, Room #'s 5511, 5513, 5515, 5517, 5519, 5521, 5523, 5525, 5527, 5529, 5531, 5533, 5525, 5537.</p> <p>2. The shared bathrooms for the following rooms 5511 and 5513, 5515 and 5517, 5521 and 5519, 5521 and 5519, 5523 and 5525, 5529 and 5527, 5533 and 5531, and 5535 and 5537 were observed on 2/18/14 at 9:50 a.m., 2/18/14 at 3:00 p.m, 2/19/14 at 9:00 a.m., a white build up was observed on the sink hardware.</p> <p>3. During an observation on the East Hall on 2/19/13 at 9:10 a.m., a wheel chair sitting outside of Room #5551 had a white substance splattered across it, the white substance continued on the floor leading into the room.</p> | | <p>5519,5521, 5523, 5525, 5527,5529, 5533, 5537 and 5551. Results were shared with the Facility Services Director and each room was scheduled for one of the following: scrub; strip/wax; or,replace flooring. This process began 3-4-14 and will be completed by 3-22-14. The Facility Services Director will share progress and challenges with the SNF PIC. The SNF PIC will monitor for compliance and make recommendations as necessary.Facility services will order sink fixtures for the following rooms by 3-14-14: 5511-5513, 5515-5517, 5519-5521, 5523-5525, 5527-5529, 5531-5533, and 5535-5537.The new sink fixtures will be in place by 3-22-14.The Facility Services Director will share progress and challenges with the SNF PIC. The SNF PIC will monitor for compliance and make recommendations as necessary.It was determined that all resident rooms have the potential to be affected. The following measures were or will be taken. The Houskeeping Manager and SNF Administrator assessed floor status of all remaining resident rooms on 2-28-14. Results were shared with the Facility Services Director and each room will be scheduled for one of the following: scrub; strip/wax; or, replace flooring. This schedule will begin 3-22-14 and will be completed in 30 days.</p> | |

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| | <p>4. On 2/19/14 at 10:10 a.m., during an interview with Housekeeper # 1 she indicated that she was the only housekeeper currently working the floor. At this time she indicated she was finished with the east end of the hall.</p> <p>On 2/20/14 at 10:00 a.m., the floor leading into Room #5551 was observed to have a white substance splattered across it.</p> <p>5. During an environmental walk through on 2/19/14 at 11:20 a.m., the Adm. (Administrator) and Housekeeping Supervisor were shown the floors and sink hardware in following Rooms #' s : 5511, 5513, 5515, 5517, 5519, 5521, 5523, 5525, 5527, 5529, 5531, 5533, 5525, 5537 and 5551. At that time both agreed the dirt was removable and that they would review the cleaning schedule and procedures. The Adm indicated he was aware of the sink hardware and that he would see what could be done.</p> <p>A document titled "Enviromental Services Department AREA</p> | | <p>The Facility Services Director will share progress and challenges with the SNF PIC. The SNF PIC will monitor for compliance and make recommendations as necessary. All remaining sink fixtures with white (mineral) build up will be replaced. This replacement will be coordinated by Facility Services and will begin 3-22-14 and will be completed in 30 days. The Facility Services Director will share progress and challenges with the SNF PIC. The SNF PIC will monitor for compliance and make recommendations as necessary. To prevent future recurrence the following will occur: Newly hired SNF housekeepers will be trained regarding cleaning/santizing and other Area Assignment expectations during their orientation. This training will be a responsibility of the Housekeeping Manager or her designee. Resident room floors will be assessed by the Housekeeping Manager on a semi annual basis and will be scheduled for one of the following by Facility Services: scrub; strip/wax; or, replace flooring. Resident sink fixtures will be placed on a semi annual preventative maintenance schedule to montior for and address white (mineral) build up. This scheduling will be a responsibility of the Facility Services Director or his designee. The Facility Services Director will summarize these</p> | | |

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| | <p>ASSIGNMENT [sic]" was provided and reviewed on 2/20/14 at 11:10 a.m. by the Houskeeping Supervisor, the document included " All Resident [sic] rooms and restrooms are to be cleaned/sanitized in their entirety, dust/wet mopped and trash picked up with all waste cans to be doble bagged, daily and/or requested)."....</p> <p>3.1- 19(f)</p> | | <p>processes and associated challenges to the SNF PIC for at least one year. The SNF PIC will montior for compliance and will make recommendations as necessary.</p> | | |