

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/20/2016
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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00201231.</p> <p>Complaint IN00201231 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 14, 15, 16, 17, &amp;, 20, 2016.</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Census bed type: SNF/NF: 61 Total: 61</p> <p>Census payor type: Medicare: 10 Medicaid: 47 Other: 4 Total: 61</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on</p>	F 0000	<p>June 30, 2016</p> <p>Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006</p> <p>Dear Ms.Rhoades:</p> <p>Please reference the enclosed 2567L as "Plan of Correction" for the June 20, 2016 Recertification and State Licensure with Complaint (IN00201231) survey that was conducted at Lake County Nursing</p>	

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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	6/22/16.		<p>and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools June 30, 2016. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community.</p> <p>The Plan of Correction submitted on July 8, 2016 serves as our allegation of compliance. The provider respectfully request a Desk review on or after July 20, 2016. Should you have any question or concerns regarding the Plan of Corrections, please contact me.</p> <p>Respectfully,</p>	

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F 0164 SS=E Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the</p>		Neysa Stewart, HFA	

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	<p>resident. Based on observation, record review, and interview, the facility failed to ensure privacy was ensured during incontinence care, medication administration and staff to resident conversations for 5 of 5 residents reviewed for privacy. (Residents #1, #4, #31, #44 and #69)</p> <p>Findings include:</p> <p>1. On 6/14/16 at 10:15 a.m., Resident #4 was observed seated in her wheelchair in the hallway. The resident's pants were wet at this time.</p> <p>At 10:41 a.m., a CNA left the resident's room to get an incontinence brief. The door to the resident's room was halfway open. The resident was positioned on top of the bed and was not clothed or covered from the waist down. The resident was visible from the hallway.</p> <p>The record for Resident #4 was reviewed on 6/16/16 at 9:54 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, dementia without behavioral disturbances, and schizophrenia.</p> <p>The 3/11/16 Quarterly Minimum Data Set (MDS) assessment, indicated the resident's Brief Interview for Mental</p>	F 0164	<p><b>F 164 PLAN OF CORRECTION</b> Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b> - Resident #4 door was closed immediately and continues to demonstrate that she was unaffected by this alleged deficient practice. - It is unclear when/how this breach of confidentiality occurred. Resident #66 did not show that he was effected negatively by this alleged deficient practice. Resident #69, Resident #31, Resident #1- did not show any negative effects from LPN#1 alleged deficient practice. <b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b> - All residents that receive incontinent care at risk for this alleged deficient practice. C.N.A was given 1:1 in-service immediately and rounds of her assignment revealed no further issues. - All residents that have information exchanged during report are at risk for this alleged deficiency. No other residents were identified to be negatively affected. - All</p>	07/11/2016			

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	<p>Status (BIMS) score was "11" indicating some cognitive impairment. The resident needed extensive assistance for toileting.</p> <p>Interview with the Assistant Director of Nursing on 6/17/16 at 1:40 p.m., indicated the door to the resident's room should have been completely closed when the aide left the room.</p> <p>2. Interview with Resident #44 on 6/14/16 at 10:30 a.m., indicated she was aware there was a new resident on the second floor that had AIDS (Acquired Immune Deficiency Syndrome) She further indicated the staff had told her the resident was HIV (Human Immunodeficiency Virus) positive.</p> <p>On 6/14/16 at 3:10 p.m., LPN #3 and LPN #4 were observed giving the end of shift report behind the Nurse's station, which was directly behind the elevators and near where other residents were either seated in their wheelchairs or on the chairs positioned by the elevator.</p> <p>The record for Resident #44 was reviewed on 6/16/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, bipolar disorder, multiple sclerosis, and major depressive disorder.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 4/1/16 indicated the</p>		<p>residents that receive meds are at risk for this alleged deficient practice. LPN #1 was given 1:1 in-service immediately. <b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b> - Nursing staff were re-inserviced regarding providing for residents privacy when giving care on 6/22/16 and 7/5/16. System for giving report was immediately reviewed and modified. LPN #1 was immediately given 1:1 in-service on 6/17/16 <b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> DON / Designee will monitor 4 staff members 5 times a week for 4 weeks <b>alternating on all shifts</b>, then 2 staff members 5 times a week for 3 months <b>alternating on all shifts</b> to ensure that privacy is maintained during care, that the confidentiality of patient health information and medical records is ensured. <b>Any issues identified or observed will be corrected immediately.</b> The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. <b>5. Completion date systemic changes will be completed:</b> 7/11/16</p>				

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	<p>resident had a BIMS (Brief Interview for Mental Status ) score of 15, indicating she was alert and oriented.</p> <p>A current and updated plan of care dated 4/15/16, indicated the resident had a history of telling untruthful statements and making false allegations. The resident had asked staff to answer confidential information regarding other residents. The Nursing approaches were to have staff remain professional and provide courteous customer service daily with the resident while providing care daily.</p> <p>Interview with LPN #3 on 6/14/16 at 1:30 p.m., indicated there was a resident with HIV who was just admitted to the facility on the second floor. She further indicated she had received her shift report from the midnight nurse at the Nurse's station.</p> <p>Interview with the Director of Nursing, on 6/17/16 at 9:15 a.m., indicated she was unaware how Resident #44 received her information regarding the new resident having HIV.</p> <p>3. On 6/17/16 at 5:50 a.m., LPN #1 was observed preparing medications for Resident #69. At that time, she was observed standing in front of the medication cart which was parked in</p>			

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	<p>front of the resident's doorway. The LPN then left the medication cart and walked in to the resident's room. At that time, the Medication Administration Record (MAR) was left open and on top of the med cart in full view of all of the residents and visitors. The MAR included a list of all the resident's medications and diagnoses.</p> <p>4. On 6/17/16 at 6:10 a.m., LPN #1 was observed preparing medications for Resident #31. At that time, she was observed standing in front of the medication cart which was parked in front of the resident's doorway. The LPN then left the medication cart and walked away, indicating she had to retrieve her stethoscope. The Medication Administration Record (MAR) was left open and on top of the cart in full view of all of the residents and visitors. She then returned to the medication cart, retrieved the resident's medications and walked into the room. The MAR was again left open in full view.</p> <p>5. On 6/17/16 at 6:25 a.m., LPN #1 was observed preparing medications for Resident #1. At that time she was observed standing in front of the medication cart which was parked in front of the resident's doorway. The LPN then left the medication cart and walked</p>			

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F 0278 SS=D Bldg. 00	<p>away, indicating she had to check the medication room. The Medication Administration Record (MAR) was left open and on top of the med cart in full view of all of the residents and visitors. LPN #1 then returned to the cart, retrieved the resident's medications from inside the cart, and walked into the room. The MAR was again left open in full view.</p> <p>Interview with LPN #1 at the time, indicated she should have closed the MAR whenever she left the med cart.</p> <p>Interview with the Director of Nursing on 6/17/16 at 6:43 a.m., indicated the Nurse should have closed the MAR every time she was out of sight from the medication cart.</p> <p>3.1-3(p)(2) 3.1-3(p)(4)</p> <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</p>			

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	<p>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 ensure each comprehensive assessment was accurate related to nutrition and significant weight loss for 1 of 3 residents reviewed for nutrition of the 11 residents who met the criteria for nutrition. (Resident #30)</p> <p>Finding includes:</p> <p>The record for Resident #30 was reviewed on 6/16/16 at 8:46 a.m. The resident's diagnoses included but were not limited to, HIV, high blood pressure, and anemia.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 7/25/15 indicated the</p>	F 0278	<p><b>F 278</b></p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p>	07/11/2016

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	<p>resident's weight was 203 pounds with no significant weight loss.</p> <p>The Quarterly MDS assessment dated 10/25/15 indicated the resident's weight was 192 pounds and there was an unplanned significant weight loss.</p> <p>The Quarterly MDS assessment dated 1/25/16 indicated the resident's weight was 188 pounds and there was an unplanned significant weight loss.</p> <p>The Quarterly MDS assessment dated 4/26/16 indicated the resident's weight was 188 pounds and there was an unplanned significant weight loss.</p> <p>The Registered Dietitian (RD) Progress Note dated 7/22/15 indicated the resident had a gradual weight loss but not significant.</p> <p>RD Progress Notes dated 10/24/15 and 1/27/16 indicated the resident had no significant weight loss.</p> <p>The last RD Progress Note dated 4/27/16 indicated the resident had no significant weight change with a 2.1% weight loss in 180 days.</p> <p>Interview with the MDS Coordinator on 6/16/16 at 10:18 a.m., indicated the</p>		<p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>- Resident #30 MDS was modified and corrected.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>- All residents that have an MDS 'section K' completed is at risk for this alleged deficient practice. An audit of the MDSs that triggered due to inaccurate coding of section K was completed and modifications made as needed.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p>	

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	<p>Dietary Food Manager completes the Nutrition section on the MDS. She indicated the resident was reviewed a couple weeks ago, because of triggering a significant weight loss. She indicated the MDS was inaccurately coded for significant weight loss.</p> <p>3.1-31(i)</p>		<p>- The system for completing MDS section K was reviewed and modified. The Registered Dietitian will code this section starting 6/29/16.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>DON / Designee will monitor and assess the accuracy of <b>all sections of 5 MDS</b> weekly for four weeks. Then <b>all sections of 3 MDS</b> weekly for 3 months. <b>Any issues found will be addressed immediately.</b> The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed:</b> 7/11/16</p>	

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F 0311 SS=D Bldg. 00	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure each resident who required assistance with Activities of Daily Living (ADLs) received at least two showers a week for 1 of 4 residents reviewed for ADLs of the 16 residents who met the criteria for ADLs. (Resident #53)</p> <p>Finding includes:</p> <p>Interview with Resident #53 on 6/14/16 at 2:33 p.m., indicated he had to remind and beg someone to give him a shower every week. He further indicated he had not had a shower in over a month.</p> <p>The record for Resident #53 was reviewed on 6/16/16 at 10:06 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, high blood pressure, history of heart attack, hemiplegia and hemiparesis following a stroke.</p>	F 0311	<p><b>F 311 PLAN OF CORRECTION</b> Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b> R#53 received a shower and has shown no negative effects from this alleged deficient practice. <b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b> All residents that consent to showers at risk for this alleged deficient practice. None of the residents that reside on the second floor were observed to be affected by this alleged deficient practice. <b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b> The system for giving showers has</p>	07/11/2016

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	<p>The Annual Minimum Data Set (MDS) assessment dated 4/17/16 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, indicating he was alert and oriented. The resident had no behaviors. The resident indicated it was very important to choose between a bath and shower. The resident had impairment to one side for upper and lower extremity for range of motion. The resident needed supervision with set up for bathing.</p> <p>The current and updated plan of care dated 4/2016 indicated there was no care plan for the resident regarding his preferences or refusing care.</p> <p>The shower sheet indicated the resident was to receive his showers on Wednesdays and Fridays.</p> <p>The resident had received a shower on 4/1, 4/8, 4/13, 4/18, 4/25, 4/27, and 4/28/16 for April 2016. He received a shower on 5/2, 5/3, 5/4, 5/10, 5/18, and 5/20/16 for May 2016, and on 6/13, and 6/15/16 for June 2016.</p> <p>There was no documentation the resident had a shower on 4/5, 4/15, 4/20, 4/22, 5/13, 5/25, 5/27, 6/1, 6/3, 6/8 and 6/10/16, which would have been on a Wednesday or Friday.</p>		<p>been reviewed and modified as needed. Nursing staff were in-serviced regarding changes on 7/5/16 <b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> DON / Designee will monitor 3 residents daily 5 days a week <b>for 4 weeks.</b> Then 10 resident per week for 3 months to ensure shower schedule is being followed. <b>Any identified issues will be addressed immediately.</b> The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. <b>5. Completion date systemic changes will be completed: 7/11/16</b></p>	

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F 0312 SS=D Bldg. 00	<p>Interview CNA #1 on 6/16/16 at 2:50 p.m., indicated he was unaware of the location of the current shower list and he did not know when the resident was to receive his shower.</p> <p>Interview with the Wound Nurse on 6/17/16 at 2:30 p.m., indicated she keeps track of the showers and baths for the residents. She indicated the resident only needed supervision when he took a shower. The Wound Nurse indicated the resident had not received a shower at least two times a week over the last 3 months.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a dependent resident received assistance with nail care for 1 of 4 residents reviewed for activities of daily living of the 16 residents who met the criteria for activities of daily living. (Resident #38)</p>	F 0312	<p><b>F 312</b> PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>1. The</b></p>	07/11/2016

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	<p>Finding includes:</p> <p>On 6/15/16 at 11:45 a.m., 2:00 p.m., and 3:18 p.m., Resident #38 was observed with dark debris underneath his fingernails.</p> <p>On 6/16/16 at 8:52 a.m., 10:00 a.m., and 1:15 p.m., the resident was again observed with dark debris underneath his fingernails.</p> <p>The record for Resident #38 was reviewed on 6/16/16 at 3:01 p.m. The resident's diagnoses included, but were not limited to, muscle weakness, dementia without behavior disturbances, and cerebral infarct.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 4/8/16, indicated the resident's Brief Interview for Mental Status (BIMS) score was "15" indicating he was cognitively intact. The resident needed extensive assist for personal hygiene.</p> <p>The plan of care dated 3/1/16, indicated the resident had a history of refusing showers. The interventions included, but were not limited to, if resident refuses shower, staff will offer bed bath.</p>		<p><b>corrective action taken for the resident found to have been affected by the deficient practice:</b> R#38 did allow the ADON to clean his nails during survey. He frequently declines most aspects of care. <b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b> All residents that are dependent on staff for nail care are at risk for this alleged deficient practice. An audit was completed on 6/17 and any issues with nail care was addressed immediately. <b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b> Nursing staff were re-educated on 6/22/16 and 7/5/16 regarding nail care. <b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> DON / Designee will monitor 3 residents daily 5 days a week for four weeks. Then 7 residents weekly for 3 months. <b>Any issues found will be addressed immediately.</b> The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. <b>5. Completion date systemic changes will be</b></p>	

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F 0318 SS=D Bldg. 00	<p>The ADL (Activities of Daily Living) flow sheet was reviewed. The resident received a bed bath on 6/14/16 and partial baths on 6/15/16 and 6/16/16.</p> <p>Interview with the Assistant Director of Nursing on 6/17/16 at 1:40 p.m., indicated the resident had a history of refusing showers. She indicated if the resident refused his showers, bed baths were to be given and his nails should have been cleaned.</p> <p>3.1-38(a)(3)(E)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure splints were applied and range of motion was completed as ordered for 2 of 3 residents reviewed for range of motion of the 5 residents who met the criteria for range of motion. (Residents #4 and #53)</p>	F 0318	<p><b>completed: 7/11/16</b></p> <p><b>F 318</b></p> <p>PLAN OF CORRECTION</p>	07/11/2016

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	<p>Findings include:</p> <p>1. On 6/14/16 at 10:14 a.m., Resident #4's right hand was observed closed in a partial fist. No anti-contracture device was observed in place.</p> <p>On 6/15/16 at 9:03 a.m., 1:56 p.m., and 3:18 p.m., the resident was again observed with no anti-contracture devices in place to the right hand.</p> <p>On 6/16/16 at 8:40 a.m. and 1:25 p.m., the resident had no anti-contracture device in place to the right hand.</p> <p>On 6/17/16 at 8:55 a.m., no splint device was present to the resident's right hand. A unfolded wash cloth was observed on the resident's lap.</p> <p>The record for Resident #4 was reviewed on 6/16/16 at 9:54 a.m. The resident's diagnoses included, but were not limited to, cerebral infarction, hemiplegia and muscle weakness.</p> <p>The June 2016 Physician's Order Summary (POS) indicated the resident was to have a splint to the right hand on in the morning and off in the evening. The resident was also to receive passive range of motion to the upper extremities</p>		<p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>R#4 splint applied, OT assessment has been completed. POC updated.</p> <p><b>R#53 splint applied and he was educated and care plan updated.</b></p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents with contractures are at risk for this alleged deficient practice. An audit was completed of these residents to ensure that ROM and proper splinting device are being applied</p>	

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	<p>6 to 7 days per week.</p> <p>The 3/11/16 Quarterly Minimum Data Set (MDS) assessment, indicated the resident had functional limitation in range of motion on one side of the upper extremities.</p> <p>The plan of care dated 7/20/10 and reviewed on 3/18/16, indicated the resident required the use of a right hand splint to assist in preventing avoidable decline to the extremity. The interventions included, but were not limited to, staff to apply right hand splint on in morning and remove in evening daily for a minimum of 6 days per week and if resident refuses hand splint, may use palm protector.</p> <p>The 3/16/16 Quarterly Restorative Documentation assessment, indicated splint or brace assistance to assist in prevention of avoidable decline in ROM (range of motion) to RUE (right upper extremity).</p> <p>Resident accepts splint on in morning and off in evening at most times. The resident will tolerate wearing splint with no complaints of pain.</p> <p>Interview with the resident on 6/16/16 at 10:55 a.m., indicated that she exercised</p>		<p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>Nursing staff were re-inserviced regarding ROM/splint application on 6/22/16 and 7/5/16.</p> <p>Joint mobility assessments were completed for all residents with contractures.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>DON / Designee will monitor 3 residents daily 5 days/week for completion of ROM and application of splints. Then 5 resident per week for 3 months to ensure schedule is being followed. <b>Any identified issues will be addressed immediately.</b></p> <p>The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended</p>	

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	<p>her hand herself as much as she could. When asked if she had a splint in her room, the resident was not aware. No splints were visible in the resident's room.</p> <p>The Restorative log for the month of June 2016 was reviewed. PROM (passive range of motion) was documented as being completed on 6/1/16, 6/4/16, 6/5/16 and 6/7/16. PROM was documented as not being performed on 6/8/16 and 6/14/16. The resident refused the PROM on 6/15/16.</p> <p>Documentation was completed on the same dates for splint or brace assistance.</p> <p>Interview with the Restorative Nurse on 6/17/16 at 1:22 p.m., indicated the resident did have a splint and it should be worn as ordered. She indicated the resident was currently being seen in Restorative for PROM and splint application. The Restorative Nurse indicated the PROM and splint application had not been signed out as ordered. Further interview with the Restorative Nurse at 2:30 p.m., indicated the resident's splint was misplaced and she should have had a rolled wash cloth in her right hand.</p> <p>2. On 6/14/16 at 3:16 p.m., Resident #53 was observed with his right hand closed</p>		<p>when indicated.</p> <p><b>5. Completion date systemic changes will be completed:</b> 7/11/16</p>	

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	<p>in the shape of a fist. When asked if he could open his hand, he could not voluntarily extend his fingers all the way.</p> <p>The resident indicated at that time, he had a splint from the other facility where he used to live, but it was worn out. He further indicated the therapy department gave him a splint to use but it had someone else's name on it. The resident indicated the staff do not provide range of motion to his right hand or fingers, nor do they place the splint on his right hand.</p> <p>Both hand splints were observed on the other bed in the resident's room and not on his right hand.</p> <p>On 6/15/16 2:02 p.m., and 3:30 p.m., and on 6/16/16 at 8:40 a.m., and 9:30 a.m., the resident was observed with his right hand closed in the shape of a fist. The resident was not observed wearing a splint to his right hand on the above mentioned days and times.</p> <p>The record for Resident #53 was reviewed on 6/16/16 at 10:06 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, high blood pressure, history of heart attack, hemiplegia and hemiparesis following a stroke.</p>			

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	<p>The Annual Minimum Data Set (MDS) assessment dated 4/17/16 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, indicating he was alert and oriented. The resident had no behaviors. The resident had impairment to one side for upper and lower extremity for range of motion.</p> <p>The joint mobility limitation - range of motion and loss of voluntary movement quarterly assessment dated 1/14/16 indicated the resident had moderate to severe 26-50% range of motion for his right shoulder. The resident's right hand/fingers were moderate 51-75% for available range of motion. The resident used no splints or braces.</p> <p>The current and updated plan of care dated 4/2016 indicated there was no care plan for the resident's limited range of motion to his right hand or for the use of a splint device.</p> <p>The current Physician Order Statement dated 6/2016 indicated there was no order regarding splint application.</p> <p>There were no Restorative Therapy Progress notes by the Restorative Nurse regarding the resident's progress to review from 1/2016-6/2016.</p>			

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	<p>The Nursing Rehab Time Log for 4/2016 indicated a Restorative CNA spent 15 minutes with the resident performing Passive Range of Motion (PROM) on 4/1-4/8, 4/11-4/20, and 4/22-4/27. The Restorative CNA documented 15 minutes of PROM on 5/1-5/4, 5/11-5/13, 5/15-5/18, 5/20-5/22, 5/24-5/26, and 5/29-5/31/16. The Restorative CNA documented 15 minutes of PROM on 6/2-6/4, 6/6-6/11, and 6/13-6/15/16.</p> <p>The Nursing Rehab Time Log for the number of minutes for splint assistance indicated the Restorative CNA spent 15 minutes with the resident applying the splint on 4/1-4/8, 4/11-4/20, and 4/22-4/27. The Restorative CNA documented 15 minutes of splint application on 5/1-5/4, 5/11-5/13, 5/15, 5/20, 5/25-5/26, and 5/29-5/31/16. The Restorative CNA documented 15 minutes of splint application on 6/2-6/4, 6/6-6/11, and 6/13/16. The resident had refused to wear the hand splint on 5/2, 5/16, 5/17, 5/21, 5/24, 6/14 and 6/15/16.</p> <p>Occupational Therapy (OT) Progress notes dated 4/20/16 indicated the resident had an initial range of motion assessment for right shoulder flexion of 0-90 degrees on 4/30/16 and the range of motion was the same. The resident's right hand/wrist was not evaluated for range of motion.</p>			

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	<p>A OT Progress note dated 4/12/15 indicated the resident's right wrist, elbow, and shoulder were impaired for range of motion. The reason for referral was a decrease in Right Upper Extremity (RUE) use. The resident was not evaluated for a splint or contracture at that time.</p> <p>A OT Progress note dated 5/12/15 to 6/12/15 indicated the therapy goal was to increase RUE Range of Motion (ROM). The resident was not evaluated for a splint or contracture at that time.</p> <p>A OT Progress note dated 8/29/15 indicated the reason for referral was a decrease in the RUE. The resident was not evaluated for a splint or contracture at that time.</p> <p>Interview with COTA #1 on 6/16/17 at 10:45 a.m., indicated the resident was discharged from therapy on 5/5/16. She indicated the resident was not seen specifically for splint devices or for a contracture. The COTA indicated the last therapy session they worked with him on Activities of Daily Living (ADLs) and right upper extremity range of motion. She indicated they have not worked with him specifically for contracture or splint use. She further</p>			

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	<p>indicated she had thought the resident had a splint when he came to the facility from the hospital.</p> <p>Interview CNA #1 on 6/16/16 at 1:10 p.m., indicated the resident does not need help with getting dressed or using the bathroom. He indicated he had not provided any type of range of motion with the resident and he was unaware if the resident had a splint.</p> <p>Interview on 6/16/16 at 2:06 p.m., with the MDS Coordinator who was in charge of the Restorative Program, indicated the resident puts his splint on by himself. She indicated he does his own passive range of motion as well. When asked who monitored the resident to ensure the splint was being applied daily and if he was actively performing the range of motion, the MDS Coordinator indicated the Restorative CNAs do that. She further indicated the joint mobility assessment was supposed to be completed every quarter and there was no current assessment in the resident's record. The MDS Coordinator indicated if she remembered correctly, she had thought the resident was doing the passive range of motion himself and putting on the splint at night, however, there was no documentation to indicate that happened. She further indicated</p>			

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F 0322 SS=D Bldg. 00	<p>there were no Restorative Progress notes regarding the resident's progress of his passive range of motion or splinting application. She indicated the only documentation was from the Restorative CNAs for the actual time spent for range of motion and for the splinting application.</p> <p>Interview with the resident on 6/17/16 at 7:20 a.m., indicated the MDS Coordinator came down to see him yesterday late afternoon regarding the splint and range of motion. He indicated he had put the splint on his right hand before but not everyday. The resident further indicated no staff from the facility had ever come down to his room and exercised his hand or helped him apply the splint on a daily basis. He indicated he was aware he needed to wear the splint so his hand would not become further contracted. The resident stated, "It would have been nice if staff would have provided some instruction and guidance with the splint."</p> <p>3.1-42(a)(2)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of</p>				

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	<p>a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with Percutaneous Endoscopic Gastronomy (PEG) tubes received the necessary care and treatments related to medication administration for 1 of 1 resident reviewed for PEG tubes. (Resident #31)</p> <p>Finding includes:</p> <p>On 6/17/16 at 6:25 a.m., LPN #1 was observed preparing medications for Resident #31. She dispensed one pill from her med cart, crushed it, then poured the contents into a plastic pill cup. The LPN then walked into the resident's room and donned clean gloves. She placed her stethoscope over the resident's stomach and listened for bowel sounds. At this time she did not check for tube placement. The LPN then proceeded to</p>	F 0322	<p><b>F 318</b></p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>R#4 splint applied, OT assessment has been completed. POC updated.</p>	07/11/2016

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	<p>check for residual and administer the resident's medication.</p> <p>Interview at the time, with LPN #1, indicated, she should have checked the resident's tube for proper placement prior to administering the medication.</p> <p>The record for Resident #31 was reviewed on 6/17/16 at 12:00 p.m. The resident's diagnoses included, but were not limited to, dysphasia, dementia, and PEG tube.</p> <p>The current care plan dated 4/2016, indicated the resident had a PEG tube related to dysphasia. The Nursing Approaches included, but were not limited to, check tube for placement and patency.</p> <p>Interview with the Director of Nursing on 6/17/17 at 6:43 a.m., indicated nursing staff should check for placement before each medication administration.</p> <p>Review of the current Enteral Tube Medication Administration policy dated 11/14/14, provided by the Assistant Director of Nursing on 6/17/16 at 11:55 a.m., indicated "With gloves on, check for proper tube placement using air and auscultation only."</p>		<p>R#53</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents with contractures are at risk for this alleged deficient practice. An audit was completed of these residents to ensure that ROM and proper splinting device are being applied</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>Nursing staff were re-inserviced regarding ROM/splint application on 6/22/16 and 7/5/16.</p> <p>Joint mobility assessments were completed for all residents with contractures.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established</b></p>	

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F 0323 SS=E Bldg. 00	3.1-44(a)(2)  483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure	F 0323	<b>is to:</b>  DON / Designee will monitor 3 residents daily 5 days/week for completion of ROM and application of splints. Then 5 resident per week for 3 months to ensure schedule is being followed. <b>Any identified issues will be addressed immediately.</b>  The audits will be discussed during our monthly QA meeting.  QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.  <b>5. Completion date systemic changes will be completed:</b> 7/11/16	07/11/2016

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	<p>assist rails were not loose for 3 of 3 residents reviewed for accidents of the 3 who met the criteria for accidents. The facility also failed to ensure doors in resident rooms would open after being closed. (Residents #4, #7, #53, and Room 128-1)</p> <p>Findings include:</p> <p>1. On 6/15/16 at 9:05 a.m., the left circular assist rail on Resident #4's bed was observed to be loose and would turn in a full circular motion. At 1:56 p.m., the resident was seated in a wheelchair next to her bed. The resident was holding onto the assist rail with her left hand. At 3:18 p.m., the resident was in her room in bed asleep. The assist rail was turned in the opposite direction.</p> <p>On 6/16/16 at 8:44 a.m., the assist rail to the left side of the bed remained loose. The Director of Nursing entered the resident's room at this time, She indicated the assist rail was indeed loose and she was able to pull the assist rail out of its holder with no resistance. She indicated she would notify the Maintenance Supervisor right away.</p> <p>The record for Resident #4 was reviewed on 6/16/16 at 9:54 a.m. The resident's diagnoses included, but were not limited</p>		<p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>R#4 and R#7 left circular assist rails were repaired on 6/16/16. Room 128-1 left and right Halos Safety Rings were repaired on 6/16/16. R#53 room door was repaired on 6/14/16.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the</b></p>	

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	<p>to, cerebral infarction, muscle weakness, and hemiplegia.</p> <p>The June 2016 Physician's Order Summary (POS), indicated the resident was to have halo assist rails times two for bed mobility.</p> <p>The 3/16/16 Quarterly Fall Risk assessment, indicated the resident scored a "20" a high risk for falls.</p> <p>Interview with the Maintenance Supervisor on 6/21/16 at 2:30 p.m., indicated the resident's side rail was loose and had been replaced.</p> <p>2. On 6/15/16 at 9:47 a.m., the left circular assist rail on Resident #7's bed was observed to be loose. At 1:55 p.m., the resident was seated on the side of the bed in his room watching television. At 3:18 p.m., the resident was in his room in bed sleeping.</p> <p>The record for Resident #7 was reviewed on 6/15/16 at 2:11 p.m. The resident's diagnoses included, but were not limited to, muscle weakness and lack of coordination and history of falling.</p> <p>The 4/22/16 Quarterly Fall Risk assessment, indicated the resident scored a "20" a high risk for falls.</p>		<p><b>same deficient practice:</b></p> <p>A house audit of all circular assist rails was completed on 6/16/16 by the Maintenance Department to ensure proper function any issues found were addressed immediately. On 6/14/16 a house audit of all resident room doors were checked to ensure they open properly any issues found were addressed immediately. All resident have the potential to be affected by the deficient practice. No other residents were identified as being adversely affected.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b>The Maintenance and Environmental Director and maintenance staff were in-service by the Administrator on 6/24/16 regarding monitoring circular assist rails and resident room doors for proper function and maintaining an accident and hazard free environment. Nursing, Housekeeping and maintenance was re-inserviced on 6/24/16 - 6/27/16 regarding circular assist rails and resident room doors checking for proper function by the ADON and Maintenance Director.</p>	

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	<p>Documentation in the Nursing Progress notes dated 5/14/16 at 11:48 p.m., indicated the resident had slipped and fallen while ambulating to the bathroom.</p> <p>Interview with the Maintenance Supervisor on 6/17/16 at 2:45 p.m. indicated the assist rail was loose and it was readjusted.</p> <p>3. On 6/14/16 at 2:52 p.m., Resident #53 was observed in his room with the room door closed. At that time, when he tried to leave his room, the door would not open. The resident tried several times to open the door but was unable. The resident was unable to use both arms to pull the door open due to having some limited range of motion to his right arm and hand.</p> <p>The resident indicated at that time, the same thing had happened to him yesterday afternoon. He indicated after a CNA had helped him his room, he left and closed the door. The resident indicated when it was time to go to the dining room for dinner, he could not get the door open himself. He indicated he had to call down to the front desk and have someone come and open the door for him.</p> <p>Interview with the Maintenance Director</p>		<p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will monitor all residents with circular assist rails on each floor 5 days a week for 4 weeks and then 7 resident with circular assist rails on each floor 5 days a week for 3 months &amp; 10 resident room doors 5 days a week for 4 weeks and the n 5 resident room doors weekly for 3 months to insure the deficient practice does not reoccur. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for <u>three</u> consecutive months. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed:</b> <b>7/11/16</b></p>	

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F 0371 SS=E	<p>on 6/14/16 at 3:15 p.m., indicated the door would not open from the inside. He indicated it could have been from the paint on the door or from the high humidity due to being on the second floor.</p> <p>4. On 6/15/16 at 1:39 p.m. and 3:44 p.m., the left and right side Halo Safety Rings (Circular Side Rail) in room 128-1 were observed in the upright position. At those times, the Halo Safety Rings were loose and wobbled back and forth.</p> <p>On 6/16/16 at 7:55 a.m., and 3:35 p.m., the left and right side Halo Safety Rings in room 128-1 were observed in the upright position. At those times, the Halo Safety Rings were loose and wobbled back and forth.</p> <p>Interview with the Maintenance Supervisor on 6/16/16 at 3:36 p.m., indicated he was unaware the Halo Safety Rings were loose. He further indicated it needed to be fixed.</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE,</p>			

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Bldg. 00	<p><b>STORE/PREPARE/SERVE - SANITARY</b> 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 and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to an accumulation of dirt, dust, and debris on floors, shelves, and food carts in 1 of 1 Kitchen observed. (The Main Kitchen)</p> <p>Findings include:</p> <p>The following was observed during the Kitchen Sanitation Tour on 6/13/16 at 8:53 a.m., with the Dietary Manager:</p> <p>a. There was an accumulation of dust, debris, and food crumbs on the metal shelves throughout the entire kitchen.</p> <p>b. There was a dried white substance on the metal shelves of the steam table.</p> <p>c. There was an accumulation of dust and dirt on the top of the oven.</p> <p>d. There was an accumulation of dust and dirt on the top of the shelf over the stove.</p>	F 0371	<p><b>F371 PLAN OF CORRECTION</b> Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The corrective action taken for the resident found to have been affected by the deficient practice: 1. All areas cited during Dietary Sanitation Tour were addressed immediately. On 6/13/16 the kitchen was deep cleaned. A) The dust, debris and food crumbs on the metal shelves throughout the kitchen were cleaned. B) The metal shelves on the steam table was cleaned of dried white substance. C) The top of the oven was cleaned of dust and dirt. D) The top shelf over the stove was cleaned of dust and dirt. E) The accumulation of debris and dried food substance on the black transportation cart was cleaned and sanitized. F) Underneath the metal grates on the metal transportation cart was cleaned of liquid brown substance. G) The kitchen floor was cleaned and sanitized. H) The dry food</p>	07/11/2016

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	<p>e. The black transportation cart had an accumulation of debris and dried food substance.</p> <p>f. The metal transportation cart had a liquid brown substance underneath the metal grates.</p> <p>g. The floor of the kitchen was dirty.</p> <p>h. The floor in the dry food pantry was dirty.</p> <p>Interview with the Dietary Manager at that time, indicated the above items were in need of cleaning.</p> <p>3.1-21(i)</p>		<p>pantry floor was cleaned and sanitized. 2. <b>The corrective action for those residents having the potential to be affected by the same deficient practice:</b> All residents that reside in the facility and eat meals prepared in the facilities kitchen are at risk for this alleged deficient practice. No residents were identified as being affected from this alleged deficient practice. 3. <b>The measures put into place and a systemic change made to ensure the deficient practice does not reoccur:</b> Dietary staff were re-inserviced concerning dietary cleaning schedule, kitchen sanitation and areas cited on 6/22/16 and 6/27/16. Dietary cleaning check off system has been implemented. 4. <b>To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> Dietary Manager will audit cleaning schedules for completion 5 days a week for four weeks and then 3 days a week for 3 months. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5.</p>	

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F 0431 SS=E Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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> <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 and interview, the</p>	F 0431	Completion date systemic changes will be completed: 7/11/16	07/11/2016

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	<p>facility failed to ensure each resident's medications were securely stored for 1 of 2 medication carts on the First Floor and 1 of 2 Emergency Drug Kits (EDK) on the First Floor. (Cart A and EDK Box for Halls A and B)</p> <p>Findings include:</p> <p>1. On 6/17/16 at 6:25 a.m., LPN #1 was observed preparing medications for Resident #1. At that time she was observed standing in front of the medication cart which was parked in front of the resident's doorway. The LPN then walked away from her cart indicating she was going to the medication room. At that time, the cart was left unattended and unlocked. She then returned to the med cart, retrieved the resident's medication from inside the cart and walked into the room. The cart was again left unattended and unlocked.</p> <p>Interview at the time with the LPN indicated her medication cart should be locked when left unattended.</p> <p>Interview with the Director of Nursing on 6/17/16 at 6:43 a.m., indicated it was her expectation for nursing staff to secure their medication carts by locking them whenever they are left unattended.2. On 6/15/16 at 9:12 a.m., the 1st floor</p>		<p><b>F 431</b></p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>LPN #1 received 1:1 in servicing immediately.</p> <p>Locks were replaced on the EDK on 6/15/16.</p>	

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	<p>medication room was observed. The EDK box was observed to be unlocked. (Drawers 2, 3, 4, 5, &amp; 10). There were 43 residents who resided on the 1st Floor of the facility.</p> <p>Interview at that time with LPN #2 indicated all the EDK box drawers should have been locked.</p> <p>Interview with the Director of Nursing (DON) on 6/15/16 at 9:35 a.m., indicated all the drawers on the EDK box should have been locked.</p> <p>3.1-25(m)</p>		<p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents that receive meds are at risk for this alleged deficient practice.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>Nurses were re-inserviced on 6/22 and 7/5 regarding securing of meds.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>DON / Designee will monitor <b>nursing staff on all shifts 5</b> days a week for four weeks to ensure the security of the med</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/20/2016
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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.		<p>carts and EDK. Then 3 times a week for 3 months. <b>Any issues found will be addressed immediately.</b> The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed:</b> 7/11/16</p>	

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure infection control standards and policies were maintained related to ensuring all staff were aware of current isolation status and proper protective equipment (PPE) for 1 of 1 resident in isolation, proper storage of resident's reusable disposable equipment and clothing for 1 of 2 Floors, and proper handwashing between each resident interaction during medication pass for 2 of 8 residents observed during medication pass. (Residents #1, #31, and #68 and Rooms #106-2, #112-2, #113-1, #114-1, #116-2, and #117-2)</p> <p>Findings include:</p>	F 0441	<p><b>F 441</b></p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p>	07/11/2016

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	<p>1. On 6/16/16 at 9:18 a.m., QMA #1 was observed preparing medications for Resident #68. There was an isolation sign observed on the outside of the resident's door.</p> <p>Interview at the time with the QMA, indicated she was aware the resident was in isolation, however, she was not aware of the type of isolation or the PPE to be worn when coming into contact with the resident. She indicated she was not given report at the beginning of her shift.</p> <p>Interview with RN #5 on 6/16/16 at 10:48 a.m., indicated she was not aware of the current isolation status of residents on the unit. She then walked away to clarify the information with the Assistant Director of Nursing. When the RN returned, she indicated Resident #68 was in contact isolation and universal precautions should be used. She further indicated the resident's clinical conditions were communicated to the staff during morning report.</p> <p>Interview with Housekeeper #1 on 6/17/16 at 9:00 a.m., indicated he was not aware of any current residents on isolation precautions.</p> <p>Interview with the Director of Nursing (DON) on 6/16/16 at 10:31 a.m.,</p>		<p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>- On 6/22/16 and 7/5/16 staff were re-in serviced regarding isolation and proper equipment to be worn when caring for residents requiring isolation.</li> <li>- Resident that resides in 114-1 prefers to keep his urinal on his over bed table he has been educated and care plan was updated to reflect this request.</li> <li>- Resident in 106-2 prefers to keep his urinal on the side of his garbage can. He has been educated and his care plan was updated to reflect his wishes.</li> <li>- The clothes in 112-2 and 113-1 were picked up and taken to laundry.</li> <li>- The nurse was given 1:1 education on handwashing.</li> </ul>	

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	<p>indicated Resident #68 was admitted on 6/10/16 and she was in contact isolation. She further indicated all department heads (except Maintenance) meet during morning huddle for updates and/or discussions. Among those topics discussed were residents in isolation and it was the responsibility of the department heads to communicate to the staff any pertinent resident information up to and including isolation precautions. She further indicated, if a staff member was unaware of isolation precautions it was also their responsibility to ask.</p> <p>2. On 6/15/16 at 9:43 a.m., there was a urinal stored on the bedside table next to a food tray in Room 114-1. Two residents resided in this room.</p> <p>b. On 6/15/16 at 9:57 a.m., there were clothes stored on the closet floor uncontained in Room 112-2. Two residents resided in this room.</p> <p>c. On 6/15/16 at 10:31 a.m., there was a urinal hanging from the waste basket next to the bed in Room 106-2. Two residents resided in this room.</p> <p>d. On 6/15/16 at 10:41 a.m., there was a pink wash basin and a pink bed pan stored in the closet uncovered in Room 116. One resident resided in this room.</p>		<p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <ul style="list-style-type: none"> <li>- No other residents are currently in isolation. No other residents were found to be affected by this alleged deficient practice.</li> <li>- All residents that have a preference to place their urinal in undesirable places are at risk for this alleged deficient practice. An audit was completed and education was completed and Care plans updated as necessary.</li> <li>- All residents with personal clothing are at risk for this alleged deficient practice. The current closet cleaning schedule was reviewed and given to the "Bed Makers" to follow. An audit of all closets was completed on 6/16/16 and any identified problems regarding clothing on the floor was corrected immediately.</li> </ul>	

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	<p>e. On 6/15/16 at 11:27 a.m., there was a pink wash basin stored in the closet uncovered in Room 117. One resident resided in this room.</p> <p>f. On 6/15/16 at 11:38 a.m., there were clothes stored on the closet floor uncontained in Room 113-1. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor and the Housekeeping Supervisor on 6/17/16 at 1:30 p.m., indicated the above items were not stored properly.</p> <p>3. On 6/17/16 at 6:10 a.m., LPN #1 was observed preparing medications for Resident #31 to be administered via his Percutaneous Endoscopic Gastrostomy (PEG) tube. The LPN entered the room and donned clean gloves. She did not wash her hands with soap and water upon entering the room nor did she use hand sanitizer before donning the gloves. She then proceeded to administer the medication via the resident's PEG tube. When the LPN finished administering the medication, she removed her gloves and exited the room. She did not wash her hands with soap and water nor did she use hand sanitizer.</p>		<p>- All residents that use bed pans and bath basins are at risk for this alleged deficient practice. An audit was completed on 6/16 to ensure that bed pans and bath basins are stored correctly.</p> <p>- All residents that receive meds are at risk for this alleged deficient practice. No other residents were identified to be effected.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>On 6/22/16 All staff were re-educated regarding isolation and the signage means.</p> <p>On 6/22/16 and 7/5/16 all nursing staff were re-educated regarding proper storage of urinals, bed pans, and bath basins and clothing. Residents care plans were updated as necessary. Nurses were also re-educated regarding handwashing per policy.</p>	

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	<p>The LPN returned to her medication cart and was observed preparing medications for Resident #1. The LPN entered the room and administered the medication to the resident. She did not wash her hands with soap and water nor did she use hand sanitizer before entering the room prior to administering the medication.</p> <p>Interview with the Director of Nursing on 6/17/16 at 6:43 a.m., indicated the LPN should have washed her hands between each resident interaction during the medication pass.</p> <p>Review of the current Handwashing/Hand Hygiene policy dated 11/2013, provided by the Assistant Director of Nursing on 6/17/16 at 11:55 a.m., indicated "When hands are not visibly soiled, employees may use an alcohol-based hand rub containing 60-95% ethanol or isopropanol in all of the following situations, including but not limited to:</p> <ul style="list-style-type: none"> <li>a. before direct contact with residents;</li> <li>b. after direct contact with a resident but prior to direct contact with another resident.</li> </ul> <p>3.1-18(b)(1) 3.1-18(l)</p>		<p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>DON / Designee will monitor nursing staff on <b>alternating shifts</b> 5 rooms 5 days a week for four weeks for proper storage of equipment and clothing. Then 3 rooms 5 days per week for 3 months <b>on alternating shifts.</b></p> <p>DON/Designee will monitor 1 staff member daily 5 days per week for proper handwashing then 3 staff members weekly for 3 months.</p> <p>DON/Designee will quiz 1 staff member each day regarding current residents with isolation 5 days per week for 1 month then 3 weekly for 3 months. <b>Any issues found will be addressed immediately.</b> The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>	

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained related to an accumulation of white substances underneath the handwashing sink and on the ice maker and leaking pipes in the kitchen, urine odors, holes in walls, marred walls and doors, loose heating vent covers, loose/peeling cove bases, debris in light covers, burned out light bulbs, loose closet door knobs, brown substances on floors, missing floor tiles, rusty doors and grab bars, exposed bolts, and insect strips with an accumulation of bugs on 2 of 2 floors throughout the facility and 1 of 1 kitchen areas throughout the facility. (The First and Second Floors and the Main kitchen)</p> <p>Findings include:</p> <p>1. During the Environmental tour on 6/17/16 at 1:30 p.m., with the</p>	F 0465	<p><b>5. Completion date systemic changes will be completed: 7/11/16</b></p> <p><b>F 465</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. On 6/17/16 all the</b></p>	07/11/2016

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	<p>Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>First floor</p> <p>a. Room 101: There were two loose closet door knobs, the cove bases were peeling from the wall next to the closet door and the heating vent covers were missing. Two residents resided in this room.</p> <p>b. Room 103: There was a strong urine odor in the bathroom and the cove bases behind the bedroom door were peeling from the wall. Two residents shared this bathroom.</p> <p>c. Room 105: The cove bases behind the toilet was peeling from the wall and there was a brown substance on the floor next to the toilet. Four residents shared this bathroom.</p> <p>d. Room 107: There was missing tile on the bathroom floor, exposed bolts on the toilet, an accumulation of debris in the light cover, and missing cove bases. One resident resided in this room.</p> <p>e. Room 110: There was missing tile on the bathroom floor, an accumulation of debris in the light cover, and a insect strip covered with an accumulation of bugs.</p>		<p>environmental concerns identified during the survey were immediately addressed and / or resolved.</p> <p>The 2 loose closet door knobs in room 101 were tightened.</p> <p>The bathrooms were deep cleaned and floors scrubbed in rooms 103,105, 112, 127, 201 and 203.</p> <p>Cove bases was secured to the wall in rooms 101,103,105,107 and 225.</p> <p>Missing Floor tiles were replaced in rooms 107 and110.</p> <p>Covers were placed on the exposed bolts on the toilet in room 107.</p> <p>Light covers in rooms 107 and 110 were cleaned of debris.</p> <p>The insect strip in room 110 was removed.</p> <p>The heater vent was replaced in room 101. Room111 and 114 heater vents were repaired and the heater vent in room 215 was painted.</p> <p>Bathroom light bulbs in rooms 111, 201 and 221 and 225 were replaced.</p> <p>The closet door track was repaired in room 112.</p>	

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	<p>Two residents shared this bathroom.</p> <p>f. Room 111: The heating vent covers were loose in the bedroom. Two residents shared this room. The light bulb over the sink in the bathroom was burned out. Four residents shared this bathroom.</p> <p>g. Room 112: There was a strong urine odor in the bathroom. Two residents shared this bathroom. The closet door was off the track. Two residents resided in this room.</p> <p>h. Room 113: The arms and legs of the chair near the door were marred. Two residents resided in this room.</p> <p>i. Room 114: The heating vent cover was loose and touching the floor. Two residents resided in this room.</p> <p>j. Room 123: The wall on the side of the bed was marred and there were two holes in the wall by the entrance of the room. One resident resided in this room.</p> <p>k. Room 127: There was a strong urine odor in the bathroom. Four residents shared this bathroom.</p> <p>Second Floor</p>		<p>Marred walls and doors were painted in rooms 123 and 201.</p> <p>The rusty grab bars were removed in room 201 and rust on the edge of the door was removed.</p> <p>The peeling medal molding at the bottom of the door frame in rooms 218 and 220 were repaired.</p> <p>The linking pipe underneath the hand washing sink in the kitchen was repaired.</p> <p>The accumulation of white substance on the icemaker and underneath the hand washing sink near the icemaker was cleaned immediately.</p> <p>The icemaker seal gasket was replace immediately.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b> All residents that reside in the facility are at risk with this alleged deficient practice. No residents were identified as being adversely affected.</p> <p><b>3. The measures put into place</b></p>	

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	<p>a. Room 201: There was a strong urine odor in the bathroom, the light bulb over the sink was burned out, the grab bars were rusty, and the edge of the door was rusty. Three residents shared this bathroom. The inside of the bedroom door was marred at the base. Two residents resided in this room.</p> <p>b. Room 203: There was a strong urine odor in the bathroom. Three residents shared this bathroom.</p> <p>c. Room 215-2: The heating vent covers were marred behind the head of the bed. Two residents resided in this room.</p> <p>d. Room 218: The metal molding was peeling from the bottom of the door frame. One resident resided in this room.</p> <p>e. Room 220: The metal molding was peeling from the bottom of the door frame. One resident resided in this room.</p> <p>f. Room 221: The light bulb over the sink in the bathroom was burned out. One resident resided in this room. This bathroom was not shared.</p> <p>g. Room 225: The light bulb over the sink in the bathroom was burned out and the cove bases were peeling from the wall. Two residents shared this</p>		<p><b>and a systemic change made to ensure the deficient practice not reoccur:</b> On 6/17/16 housekeeping and maintenance staff were re-inserviced regarding filling out repair forms, repairs and proper cleaning of bathroom light fixtures, urine odors, rusty door frames, marred walls and doors, missing floor tile, Housekeeping cleaning schedule has been revised and "Housekeeping / Maintenance audit tools" have been implemented. On 6/27/16 all Department heads were re-inserviced by the Administrator/ Housekeeping Director on what to</p> <p>look for during guardian angel rounds and how use the maintenance request forms. During All Staff meeting on 6/17/16 staff were re-educated on the use of "maintenance request forms" by the Housekeeping Director &amp; Maintenance Director.</p> <p><b>F465</b></p> <p><b>4. To ensure the deficient practice does not reoccur, the</b></p>	

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F 0469 SS=E	<p>bathroom.</p> <p>Interview at that time, with the Maintenance and Housekeeping Supervisors indicated all the above items were in need of cleaning and/or repair.</p> <p>2. During the Brief Kitchen Tour with the Dietary Food Manager (DFM) on 6/14/16 at 8:53 a.m., the following was observed:</p> <p>a. There was a leaking pipe underneath the handwashing sink.</p> <p>b. The ice maker seal was peeling from the lid and water was leaking on the floor.</p> <p>c. There was an accumulation of white substances on the ice maker.</p> <p>d. There was an accumulation of white substances underneath the hand washing sink near the ice maker.</p> <p>Interview at that time with the DFM indicated the above items were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL</p>		<p><b>monitoring system established is to:</b></p> <p>Housekeeping / Maintenance Director will monitor <u>10</u> rooms <u>5</u> days a week for four weeks. Then <u>5</u> rooms weekly for <u>3</u> months. <b>Any issues found will be addressed immediately.</b></p> <p>The audits will be discussed during our monthly QA meeting. All issues found will be addressed immediately. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 7/11/16</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/20/2016	
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
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Bldg. 00	<p><b>PROGRAM</b></p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the facility remained free of pests related to ants in the therapy room and gnats on the first floor and conference room for 1 of 2 floors. (The first floor)</p> <p>Findings include:</p> <p>1. On 6/16/16 at 11:10 a.m., there were many live ants observed crawling around on the counter top and on the computer screen in the first floor therapy room.</p> <p>Certified Occupational Therapy Aide (COTA) #1 indicated at that time, the ants were always crawling around on the counter and on the computer screen.</p> <p>Interview with the Maintenance Director on 6/16/16 at 11:30 a.m., indicated the therapy department had food on the floor and on the counter tops and the ants were drawn to it.</p> <p>The Pest Control report was reviewed on 6/20/16 at 9:54 a.m. The company last visited the facility on 6/7/16. They treated the first and second floors with spray for preventative maintenance. They also treated the kitchen for gnats</p>	F 0469	<p><b>F469</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b> No residents were affected by the alleged deficient practice.</p> <p>The Therapy Room was deep cleaned and sprayed for ants on 6/16/16. The Conference room was deep cleaned on 6/22/16 and new product to eliminate gnats were placed in the conference</p>	07/11/2016			

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	<p>that were observed behind the baseboard breeding due to a build up of water getting behind the baseboards.</p> <p>2. On 6/16/16 at 8:43 a.m., several gnats were observed flying around the First Floor hallways.</p> <p>3. On 6/14/16 through 6/17/16 there were several gnats observed flying around the Conference Room from 9:00 a.m. to 3:30 p.m.</p> <p>Interview with the Director of Nursing on 6/17/16 at 9:00 a.m., indicated the gnats were a problem and the pest control company had been called.</p> <p>3.1-19(f)(4)</p>		<p>room sink drain. The first floor hallways were deep cleaned 6/24/16. Monroe Pest Control came out to exterminate on 6/21/16.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b>All residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and systemic change made to ensure the deficient practice does not reoccur:</b> On 6/17/16 All staff were In-serviced by the Environmental Director regarding filling out maintenance request form and notifying housekeeping and maintenance when pests are noted. The deep Cleaning schedule was revised. A new Pest Control company was obtained on 6/21/16 (Smithereen Pest Management Services) will service the facility to ensure the</p>	

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			<p>facility is free is free of pests and rodents.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is:</b></p> <p>The Maintenance Manager / Designee will <b>monitor the Conference room and first floor hallway for gnats five days a week for 3 months. Any issues found will be addressed immediately.</b> The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed: 7/11/16</b></p>	