STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00152304. Complaint IN00152304-Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 4, 5, 6, 7, 8, and 11, 2014 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Survey team: Yolanda Love, RN-TC Lara Richards, RN (August 5, 6, 7, 8, and 11, 2014) Janelyn Kulik, RN (August 4 and 5, 2014) Heather Tuttle, RN (August 4, 5, and 6, 2014) Cynthia Stramel, RN Census bed type: SNF/NF: 124 Total: 124 Census payor type: Medicare: 14	F000000	Please accept the following as the facility's credible allegation of compliance. 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 facility also respectfully requests a desk review for compliance of the deficiencies noted in this survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Medicaid: 100 Other: 10 Total: 124 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on August 14, 2014, by Janelyn Kulik, RN.			
F000278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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			

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	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. Clinical disagreement does not constitute a material and false statement.			
	Based on observation, interview and record review the facility failed to ensure a resident was accurately assessed related to his dental status for 1 of 1 resident reviewed for dental status. (Resident #83) Findings include: On 8/5/14 at 2:50 p.m., Resident #83 was observed in the Daisy Lane dining room. He did not appear to have any teeth, and was not wearing dentures. Interview with LPN #2 at that time indicated he did not have any natural teeth, and he did not wear his dentures any longer. The resident's record was reviewed on 8/7/14 at 10:00 a.m. The resident was admitted to the facility on 10/6/12. The resident's diagnoses included, but were not limited to, Alzheimer's dementia. There was not a care plan related to dental status in the resident's record.	F000278	F 278 **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice;** The 10/14/13 annual Minimum Data Set Assessment for R 83 was modified. An annual Minimum Data Set Assessment with an ARD date of 8-5-14 wascompleted for R 83. **How the facility will identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Facility audit completed by social services to identify residents who wear dentures. These residents were checked against MDS assessment to ensure accurate documentation. The MDS nurse reassessed R 83's oral/dental status. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur;** The Director of Nursing in serviced the MDS nurses on	08/29/2014

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	A Minimum Data Set (MDS) Annual Assessment dated 10/14/13 and an MDS Quarterly Assessment dated 5/16/14, indicated under the oral/ dental status sections, that the resident had no issues, including being edentulous (having no teeth), or having loosely fitting dentures. Interview with the Unit Manager on 8/7/14 at 2:46 p.m. indicated the resident did not have any natural teeth when he was admitted to the facility. She indicated he used to wear dentures, but stopped wearing them in December. 3.1-31(d)(3)		accurate codingincluding coding accurate oral/dental status. Nurses were in serviced on accurate coding including coding accurate oral/dental status. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance programs will be put into place;** Weekly the MDS coordinators/designee will cross audit three residentsMinimum Date Set for accurate coding. Any inaccuracies will be immediately corrected/modified. The results of the audit will be presented to the Quality Assurancecommittee monthly for nine months. Thereafter, if determined by theQuality Assurance committee, auditing and monitoring will be done quarterly andpresent quarterly at the QA meeting. Monitoring will be on going.	
F000371 SS=D	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, record review, and interview, the facility failed to serve and store food under sanitary conditions related to glove usage and food crumbs in the freezer and walk in cooler for 1 of 1	F000371	**Facility respectfully requests a Desk Review for the compliance of the deficiencies cited in this survey What corrective action which will beaccomplished for those**	08/29/2014

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	kitchen observed. (The Main Kitchen) Findings include: 1. On 8/4/14 at 9:12 a.m., the following was observed during the Brief Kitchen Sanitation Tour: A. There were food crumbs observed under the food prep table and the steam table. B. There were food crumbs and debris on the floor under the wire racks in the walk in cooler. There was a dried food substance stuck to the floor under the wire racks. At the base of the floor the metal was rusty and eroding away from the wall. C. There was a moderate amount of food debris and crumbs noted on the floor in the freezer. There was a large build up of ice noted on the plastic drapes at the entrance of the freezer. There was also an accumulation of ice noted on the freezer wall. 2. Observation of the tray line on 8/6/14 at 11:15 a.m., indicated Dietary Cook #1 was observed wearing gloves to both of her hands. At that time, she was observed picking up the flour tortillas with her gloved hands and placing them		**residents found to have been affected by the deficientpractice.** ·Crumbs identified on the floor and under the wire racks were removed and swept up. ·Food crumbs on the food prep table were wiped down. ·Freezer floor was mopped up and food debris removed. ·In-serviced Staff on Proper Handwashing and Glove Use **How the facility will identify otherresidents having the potential to be affected by the same deficient practice** All areas are identified as having thepotential to be affected by these alleged deficient practices. **The measures the facility will take orsystems the facility will alter to ensure that the problem will be correctedand will not recur. The facility must look at the existing system and determineif a change is necessary to correct the deficiency. If a system does not existor if a revision to an existing system is necessary, then the facility mustdevelop one.** Dietary Manager/Designee has conducted educational training with personnel on practicing the correct procedures of routine cleaning of tables, floors and freezer area, along with in-servicing onhand washing and proper glove use. Dietary Manager/Designee will audit the	

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	on the resident's plates. The cook was not using any type of utensils. She was also observed picking up plates, grabbing other utensils, and handling other items with the same gloved hands. The Dietary Consultant was informed at 11:26 a.m., the cook was picking up tortillas with her gloved hands. The Consultant had intervened, but the Dietary Cook was still observed picking up and touching the tortillas with her gloved hands. Review of the current updated Infection Control Disposable Gloves policy provided by the Administrator on 8/16/14 at 1:15 p.m., indicated "Disposable gloves will be used when manual contact with ready to eat food is unavoidable. Change gloves when they have become soiled, torn or the task is changed. Used gloves are to be discarded. Employees will wash their hands after removing soiled gloves." Interview with the Dietary Food Manager and the Dietary Consultant on 8/6/14 at 11:45 a.m., indicated the cook should not be touching the food with her gloved hands after she had touched other items. 3.1-21(i)(3)		kitchen weekly to ensure cleaning schedule is enforced and compliant, and handwashing and proper glove use is observed. **Quality Assurance** Dietary Manager Designee will present a summary of audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continued and for what time period.	

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F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview and record review the facility failed to provide routine dental services for a resident that developed denture problems for 1 of 1 resident reviewed for dental status. (Resident #83) On 8/5/14 at 2:50 p.m., Resident #83 was observed in the Daisy Lane dining room. He did not appear to have any teeth, and was not wearing dentures. Interview with LPN #2 at that time indicated he did not have any natural teeth, and he did not wear his dentures. She indicated he started removing them by himself several months ago, so they no longer used them. The resident's record was reviewed on	F000412	The facility respectfully requests a desk review for compliance of the deficiencies noted in this survey F 412 **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice;** R 83 family was contacted the same day as survey and offered dental service.Resident was seen on 8/15/14. **How the facility will identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken;** All facility residents have the potential to be affected by the same allegeddeficient practice. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur;**	08/29/2014

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	8/7/14 at 10:00 a.m. The resident was admitted to the facility on 10/6/12. The resident's diagnoses included, but were not limited to, Alzheimer's dementia and oral dysphagia (swallowing difficulty). There was not a care plan related to dental status in the resident's record. A Minimum Data Set (MDS) Annual Assessment dated 10/14/13 and an MDS Quarterly Assessment dated 5/16/14, indicated under the oral/ dental status sections, that the resident had no issues, including being edentulous (having no teeth), or having loosely fitting dentures. His Brief Interview for Mental Status (BIMS) score was 03, which indicated severe cognitive impairment. A Nursing note dated 12/17/14 at 11:57 a.m., indicated the resident was observed chewing meat then spitting it out. Interview with direct care staff indicated the resident started chewing and spitting out meat over the weekend. The Physician was notified, and an order was received for a Speech Therapy evaluation. A Speech Therapy evaluation was completed on 12/17/13. His diet was changed to mechanical soft texture.		Nursing staff were in-serviced on signs and symptoms of denture discomfortand to report to social services any concerns identified. Social Services will review all in house residents who wear dentures andobserve for any discomfort and refer to dental services as needed. SocialServices will maintain a tracking system to identify residents with dentures. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance programs will be put into place;** Social Service will review 3 residents with dentures weekly to ensure careplans are in place and to observe for discomfort and refer as needed. Social Services will summarizetracking tool monthly and bring to Quality Assurance Committee. The results ofthe audit will be presented to the Quality Assurance committee monthly for ninemonths. Thereafter, if determined by the Quality Assurance committee, auditingand monitoring will be done quarterly and present quarterly at the QAmeeting. Monitoring will be on going.	

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	A Nursing note dated 12/24/13 at 12:15 p.m., indicated the resident was eating with the Speech Therapist present, "...resident noted to have more difficulty with dentures in d/t (due to) poor fit, resident noted to takeout dentures per self and continue meal without noted difficulty." A Speech Therapy note dated 2/6/14 indicated the resident was having difficulty with mechanical soft meat. His diet was downgraded to puree. Interview with the Unit Manager and Assistant Director of Nursing (ADoN) on 8/7/14 at 3:30 p.m., the Unit Manager indicated the resident did not have any natural teeth when he was admitted to the facility. She indicated he used to wear dentures, but began removing them in December. She indicated residents normally see a dentist once a year, unless they need to be seen more frequently or they declined dental services. They indicated when this resident developed denture and eating problems, he was referred to Speech Therapy, but did not receive a dental consult. The ADoN was unable to locate documentation of the resident being seen by a dentist since admission or documentation of the family refusing dental services.			

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	3.1-24(a)(3)			
F000441 SS=E	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. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by			

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	accepted professional practice. (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 hand washing was completed after direct resident contact for 2 of 9 residents observed during medication administration. The facility also failed to ensure hand washing was completed after glove removal for 1 of 9 residents observed during medication administration. The facility also failed to ensure bed pans, wash basins, urinals and denture brushes were stored properly on 2 of 3 units throughout the facility. The facility also failed to ensure a tuberculin skin test was conducted at the time of hire for 2 of 10 employee files reviewed. (Residents #71, #123, and #141. The Main Unit and Daisy Unit, and Employees #18 and #20) Findings include: 1. On 8/7/14 at 8:51 a.m., LPN #1 was observed administering medications to Resident #123. After giving the resident his medications, the LPN proceeded to prepare Resident #71's medications. The LPN did not wash her hands nor use an alcohol based hand gel in between	F000441	**The facility respectfully requests a desk review for compliance of the deficiencies noted in this survey** **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice;** R71 and R123 had no ill effects from nurse not washing hands or usinghand sanitizer after removing gloves during medication pass observation. R141 had no ill effects from nurse not washing hands or using sanitizerafter removing gloves during blood glucose monitoring and insulinadministration observation. Both residents who reside in room 12 were provided with new urinals withlids and wash basins which have been labeled, bagged and stored appropriately. Resident in room 11 bed 1 was provided with a new urinal with a lid whichhas been labeled and bagged appropriately. Both residents who reside in room 36 were provided with new bedpans andwash basins which have been labeled, bagged and stored appropriately. The urine collection container in room 47 was disposed of appropriately.Resident no longer	08/29/2014

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	resident contacts. 2. On 8/7/14 at 11:18 a.m., LPN #1 was observed performing a glucometer (a test to check the resident's blood sugar) for Resident #141. Prior to performing the glucometer, the LPN washed her hands with soap and water and put on a pair of gloves. After the completion of the glucometer, the LPN removed her gloves and threw them in the trash can prior to leaving the room. The LPN proceeded to walk out of the room and did not wash her hands or use an alcohol based hand gel after the gloves were removed. At 11:25 a.m., the LPN prepared the resident's insulin. She put on a pair of gloves, administered the insulin and removed her gloves when done. The LPN walked out of the resident's room and put the gloves in the trash can on the side of the medication cart. The LPN did not wash her hands with soap and water nor an alcohol based hand gel after removing the gloves. Interview with the Director of Nursing on 8/8/14 at 10:00 a.m., indicated LPN #1 should have washed her hands or used a hand gel in between resident contacts and when gloves were removed. Review of the facility policy titled "Hand		requires its use. Resident in room 21 bed 2 had no ill effects from the denture brush beingplaced in the sink. The denture brush was disposed of and he was provided witha new one. He no longer resides in the facility. Both residents who reside in room 42 were provided with new urinals withlids which have been labeled, bagged and stored appropriately. Employee #18 was administered a TB test on 8/12/14 with negative results. Employee #20 was administered a TB test on 8/12/14 with negative results. **How the facility will identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken;** All facility residents have the potential to be affected by the same allegeddeficient practices. LPN#1 was immediately in-serviced on hand washing and/or hand sanitizer useafter removing gloves. The nurses andQMAs were in-serviced on hand washing and/or hand sanitizer use after removinggloves. A full house audit was completed of residents who use urinals and/or bedpansand those items have been replaced with new ones, labeled, bagged and storedappropriately. Residents who prefer to have those items at the bedside hadtheir care plan updated and/or created to reflect resident preference. HR Director	

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	washing/Hand Hygiene" on 8/8/14 at 10:30 a.m., which was provided by the Director of Nursing and identified as current, indicated the following: "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: -before direct contact with residents; -after direct contact with a resident but prior to direct contact with another resident; -before donning gloves -before preparing or handling medications; -after removing gloves; The use of gloves does not replace compliance with hand-washing/hand hygiene procedures." 3. The following was observed during the Environmental Tour on 8/6/14 at 9:30 a.m., with the Maintenance and Housekeeping Directors: A. In room 12 there was an urinal with no lid on the floor at the bedside and a pink wash basin sitting on top of a garbage can in the bathroom. Both items were not contained in plastic. There were		was in-serviced to ensure TB screening was completed by thefacility upon hire. Annual TB screening was completed in house with 100%compliance in May 2014. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur;** The Director of Nursing/designee in-serviced nursing staff on the policiestitled 'Handwashing/Hand Hygiene', 'Personal Protective Equipment-Using Gloves','Perineal Care', 'Teeth/Brushing', and 'Bedpan/Urinal, Offering/Removing' withemphasis given to: 1.Staff shall follow the hand washing/hand hygieneprocedures to help prevent the spread of infections to the other personnel,residents, and visitors. 2.When hands are not visibly soiled, employees may usehand sanitizer. 1.Before donning gloves. 2.Before preparing or handling medications. 3.After removing gloves. 1.Staff shall follow the Bedpan/Urinal, Offering/Removingprocedures for appropriate storage of urinals, bedpans and urine collectioncontainers. 2.Staff shall follow the Perineal Care procedures forappropriate storage of washbasins.	

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	two residents who resided in the room. B. In room 11 there was an urinal with no lid on top of it hanging on the hand rail in the bathroom. The urinal was not contained in plastic. There were two residents who resided in the room. C. In room 36 there was a bed pan and two wash basins on the bench in shower room. All of the items were not contained in plastic. There were two residents who resided in the room. D. In room 47 there was a white urine collection container on the back of the toilet. The urine container was not contained in plastic. There were two residents who resided in the room. E. In room 21 there was a denture brush in the sink with the bristles lying directly on the sink. There were two residents who resided in the room. F. In room 42 there were two urinals hanging on the garbage can with no lids on top of them. There was another urinal lying on the floor by bed 1. All three urinals were not contained in plastic. There were two residents who resided in the room. Review of the facility "Bedpan/Urinal,		1.If the resident keeps his urinal at his bedside or onthe floor note in the resident's care plan his request to keep the urinal atthe bedside. 2.If otherwise specified by resident and documented incare plan, remove the bedpan and urinal from the bedside. 3.Label urinals, bedpans, and washbasins, place inplastic bag and store in designated storage area. 1.Staff shall follow the Teeth/Brushing procedures forappropriate storage of denture brushes. 1.When staff is done with denture cleaning or assistingwith denture cleaning, the denture brush is to be cleaned and returned to itsdesignated storage area. The Human Resource Director was in-serviced by the Administrator andClinical Nurse Consultant on the policy titled 'Tuberculosis, EmployeeScreening for' with emphasis given to: 1. Each newly hired employee will be screened for TB infection and diseaseafter an employment offer has been madeand accepted, but prior to the employee's duty assignment. 1.Newly hired employees will receive a new TB screeningtest after employment status is finalized regardless of documentation ofprevious TB screenings submitted or given prior to hire.	

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	Offering/Removing" policy provided by the Administrator on 8/11/14 at 10:36 a.m., indicated "Store the bedpan or urinal per facility policy. Do not leave it in the bathroom or on the floor". Interview with both the Housekeeping and Maintenance Directors at the time, indicated the urinals and basins should be stored in plastic bags. 4. On 8/6/14 at 2:00 p.m. the Employee files were reviewed. Employee #18 was hired on 7/23/13. She had a first step PPD (Tuberculin skin test) on 4/8/13 and it was read on 4/10/13 with negative results. The second step PPD was administered on 4/17/13 and was read on 4/19/13 again the results were negative. At the time of employment with the facility there was no other PPD administered to the employee. 5. On 8/6/14 at 2:00 p.m., the Employee files were reviewed. Employee #20 was hired on 6/25/13. She had a first step PPD on 2/19/13 and it was read on 2/22/13 with negative results. At the time of employment with the facility there was no other PPD administered to the employee. Interview with the Administrator on		2.A log will be maintained by HR to track and ensure thatall new hires are given and in house TB prior to the employee's dutyassignment. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance programs will be put into place;** Weekly the DON/designee will audit ten residents' rooms for urinals at thebedside, urinals not covered, urinals stored improperly, bedpans not storedproperly, washbasins not stored properly, urine collection containers notstored properly, and denture brushes not stored properly. Anynoncompliance will be immediately corrected and when appropriate, a care planwill be initiated/updated to specify resident preference. Weekly the DON/designee will audit five medication passes to include allshifts in order to ensure that after glove removal, staff is washing hands orusing hand sanitizer per facility policy. The Administrator/Designee will audit all new employee files for newlyadministered TB tests prior to assigned duty. The DON/designee and Administrator will present the summaries of the auditsto the Quality Assurance committee monthly for nine months. Thereafter,if determined by the Quality Assurance committee, auditing and	

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	8/6/14 at 2:30 p.m., indicated she was aware all new employees needed a PPD skin test at the time of hire. 3.1-18(b)(1)		monitoring willbe done quarterly and presented quarterly at the QA meeting. Monitoringwill be on going.	
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure each Resident's environment was clean and in good repair related to marred walls, dirty and rusty ceiling vents, marred and gouged door frames, and torn wallpaper for 2 of 3 units. The facility also failed to ensure the kitchen was clean related to dirty and rusty wheels on the transportation carts, dirty and broken floor drains, and rusty ceiling vents for 1 of 1 kitchen observed. (The Main and Daisy Units and the Main Kitchen) Findings include: 1. The following was observed on the	F000465	The facility respectfully requests a desk review for compliance of the deficiencies noted in this survey F 465 **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice;** Room 54 bathroom vent was cleaned. Room 49 handle to closet was replaced. Room was placed on schedule for roomrepairs. Room 51 ceiling tile was replaced. Vent above door was cleaned. Room wasplaced on schedule for room repairs. Room 48 bathroom door frame was repainted. Room 47 vent was cleaned. Room 52 return vent was cleaned.	08/29/2014

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	Main Unit during the Environmental Tour on 8/6/14 at 9:30 a.m. with the Maintenance and Housekeeping Directors: A. In room 15 the non skid strips were torn and missing on the floor. There were two residents who resided in the room. B. In room 29 the walls were marred by the bathroom door. The door frame was also marred and gouged. There were two residents who resided in the room. C. In room 22 the wall by the bathroom was scuffed with black marks. The bathroom door frame had chipped paint. The wall edge by the closet door was gouged by the floor. The wall on the right side of bed two was marred and there was torn wallpaper above the head of the bed. There were two residents who resided in the room. D. In room 28 the room walls by the window and across from both beds and the bathroom door were marred. There were two residents who resided in the room. E. In room 16 the bathroom door frame was chipped. There were two residents who resided in the room.		Kitchen return vents were cleaned. Kitchen drain covers and floor tile hasbeen scheduled for repair. Kitchen transportation carts have been ordered new cart wheels. **How the facility will identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken;** All facility residents have the potential to be affected by the same allegeddeficient practice. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur;** Housekeeping was in-serviced on proper room cleaning, including the ventsand return vents on the ceiling. Housekeeping Supervisor will audit five rooms weekly to ensure propercleaning of rooms takes place. Maintenance schedule was reviewed to ensure timely review of each residentroom for routine repairs and fixes is maintained. Schedule of preventative room maintenancewill be reviewed weekly by Administrator to ensure rooms are tended to timely. Facility staff were in-serviced on maintenance service tags and their use toreport any damage to walls or furniture. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance programs will be put into place;** Housekeeping Supervisor and	

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	F. In room 2 the bathroom door frame was chipped. There were two residents who resided in the room. G. In room 5 the bathroom door frame had chipped paint. There were two residents who resided in the room. H. In room 27 there was a large accumulation of white spackle on the bathroom floor. The bathroom door frame was marred. There were two residents who resided in the room. 2. The following was observed on the Daisy Unit during the Environmental Tour on 8/6/14 at 9:55 a.m. with the Maintenance and Housekeeping Directors: A. In room 54 the bathroom ceiling vent was dirty and dusty. There were two residents who resided in the room. B. In Room 49 the closet door was missing a handle and the bottom of the closet door had a hole in it. The the room door was gouged and marred, and there was a hole in the wall by the wall edge. There were two residents who resided in the room. C. In Room 51 there was a water stained		Administrator will summarize tracking toolmonthly and bring to Quality Assurance Committee. The results of the audit willbe presented to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing andmonitoring will be done quarterly and present quarterly at the QAmeeting. Monitoring will be on going.	

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	and cracked ceiling tile in the bathroom. The return vent above the room door was dusty and rusty. The wall behind the bed was marred and gouged. There were two residents who resided in the room. D. In Room 48 the bathroom door frame was marred. There were two residents who resided in the room. E. In Room 47 the return vent above the room door was dusty and rusty. The wall by bed was gouged. There were two residents who resided in the room. F. In Room 52 the return vent above the room door was rusty and dusty. There were two residents who resided in the room. Interview with the Maintenance and Housekeeping Directors on 8/6/14 at 10:20 a.m., indicated all the above was in need of cleaning and/or repair. 3. On 8/4/14 at 9:12 a.m., the following was observed during the Brief Kitchen Sanitation Tour: A. There were eight rusty ceiling return vents. B. There were four white PVC drain covers that were rusty and cracked. The			

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	pipes surrounding the drain covers were rusty. The floor by the drain cover by the stove was gouged and missing floor tile. 4. On 8/5/14 at 2:40 p.m., the following was observed during the Full Kitchen Sanitation Tour: A. There were five tall transportation carts that had dirty and rusty wheels. B. There were eight small transportation carts that had dirty and rusty wheels. Interview with the Dietary Food Manager at that time, indicated the carts were cleaned weekly. Further interview with the Dietary Food Manager the Dietary Consultant indicated all of the above was in need of cleaning and/or repair. 3.1-19(f)			