

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/06/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 30, 31, and August 1, 2, 6, 2012</p> <p>Facility Number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Survey Team: Julie Call, RN-TC Linn Mackey, RN Shelley Reed, RN Virginia Terveer, RN</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicaid: 28 Other: 2 Total: 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/10/12 by Suzanne Williams, RN</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Huntington desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 9/5/2012.</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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F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to provide a purposeful and meaningful religious activity program for 1 of 6 residents reviewed for activities of 6 who met the criteria for activities (Resident #28).</p> <p>Findings include:</p> <p>1. During an interview on 7/30/12 at 1:59 p.m., Resident #28 indicated he would like to attend a religious program in the facility that is sponsored by a church. Resident #28 indicated he enjoys reading the Bible and having time for prayer in his room, but the facility does not have a church program for residents.</p> <p>The resident's record was reviewed on 8/2/12 at 9:49 a.m. The Minimum Data Set (MDS) assessment dated 5/10/12, indicated Resident #28 scored a 15 of 15 for the brief interview for mental status (BIMS), indicating the resident was reliably</p>	F0248	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Huntington desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 9/5/2012. <u>F248</u> It is the policy of this facility to provide a purposeful and meaningful activity program, routinely offer religious services to those residents who wish to attend and involvement by local churches and religious activities when possible. <u>1. What corrective action will be done by the facility?</u> The Activity Director has contacted local churches and religious leaders to set up religious activities for the residents. The Activity Director has been able to schedule a religious activity in conjunction with a local church (specific dates will be discussed the next few</p>	09/05/2012			

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	<p>interviewable. Resident #28's diagnoses included, but were not limited to, schizophrenia, atrial fibrillation, hypertension, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and diabetes. Resident #28 had a care plan dated 5/24/12, which indicated the resident be allowed to stay in room during certain activities to read the Bible and have time for prayer.</p> <p>Review of the activity program calendar on 8/1/12 at 4 p.m., indicated no religious programs sponsored by a church.</p> <p>During an interview on 8/1/12 at 9:15 a.m., Activity Director #12 indicated she was newly appointed to the activity director position. She indicated in the past the facility has had religious services for residents, but not since she has been in the facility. She indicated she had recently contacted two local churches to provide services to residents, but they have yet to start services in the facility.</p> <p>3.1-33(a)(4)</p>		<p>weeks). Residents, including Resident #28, have been made aware of the program, and all who are interested in attending will be reminded and assisted as needed to attend the program when it occurs. In addition the Activity Director will continue with resident worship and Bible study group – activities that were already scheduled and held prior to the survey. The Activity Director and staff will encourage attendance according to individual resident preferences. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> No other residents were identified as being affected by this practice. However, if any are found in the future to desire religious activities led by local church groups, the Activity Director will contact the churches and work with the members to provide religious programs for the residents. The results of her efforts and contacts will be documented on the chart of the individual resident(s) who has requested the religious activity. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The Administrator will audit weekly activities to ensure a church sponsored religious activity is available to those residents who prefer to attend. In addition, the religious activity will be posted on the monthly activity</p>		

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			calendar that is available to each resident. If the Administrator finds that there is no church sponsored religious activity scheduled, he will review the Activity Director's documentation regarding her efforts to contact and involve community churches. If documentation is lacking, he will review the need for religious activities for residents and retrain the Activity Director on the facility expectation for church involvement in the facility activities. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will document the results of the weekly religious activity and church contact audit on the designated form. He will review the results of his audits with the QA&A committee at its monthly meeting. If the Committee renders any recommendations for improvement in this area, the Activity Director will follow up and report the results of those recommendations at the next scheduled QA&A Committee meeting. The Administrator's weekly audit will continue for the next 60 days. When that time is completed and the facility has achieved 100% compliance in this area, the QA&A Committee may decide to terminate the need for continued auditing. However, the Activity Director's efforts in providing and scheduling	

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			church-related activities will continue on an ongoing basis. <u>Date of Compliance: 9/5/12</u>	

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F0280 SS=C	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure an interdisciplinary team, including the different disciplines providing services to the residents, were in attendance at care plan meetings for 17 of 28 residents reviewed for care planning (Residents #7, 8, 10, 11, 16, 17, 19, 20, 22, 21, 25, 26, 27, 29, 30, 31 and 32), and potentially affecting all 30 residents residing in the facility.</p> <p>Findings include:</p>	F0280	<p><u>F280</u></p> <p>It is the policy of this facility to ensure members of the interdisciplinary team routinely attend care plan conferences to coordinate care and develop each resident's care plan.</p> <p><u>1. What corrective action will be done by the facility?</u> The Director of Nursing reviewed the care planning process with the interdisciplinary team on 8/16/12 and on 8/17/12 licensed nurses and CNAs were inserviced on the care planning process including the need for interdisciplinary attendance at each care plan conference.</p>	09/05/2012			

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	<p>1. During record review from July 30 through August 6, 2012, 17 of 28 residents reviewed for care planning were found to have only two staff members in attendance for their most recent care plan meeting, Social Service Designee #11 and Dietary Manager #12.</p> <p>During an interview on 8/2/12 at 9:40 a.m., the DoN (Director of Nursing) indicated the Minimum Data Set (MDS) Coordinator is the person who has attended the care plan meetings in the past. The MDS position is currently open, and the last date of service was April 21, 2012. She indicated no nursing staff have been in attendance for the care plan meetings.</p> <p>During an interview on 8/6/12 at 10:40 a.m., Social Service Designee (SSD) #11 indicated the MDS Coordinator was in the facility every three months for care plan meetings but has not been recently involved, because she no longer works for the facility. She indicated the nursing staff, including the DoN, do not attend</p>		<p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents have the potential to be affected. No residents were found to be negatively affected as all resident needs are routinely met following the established care plan. However, if the Administrator or other member of the IDT (interdisciplinary team) finds that the participants in care plan conferences are not representative of the different disciplines present in the facility, the Administrator will address this issue with the managers of the disciplines found to be absent. The managers will be retrained by the Administrator on the facility policy requiring multiple discipline attendance at care plan conferences – continued noncompliance will be addressed with progressive discipline.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>A care plan conference schedule will be provided to each member of the interdisciplinary team by a designee appointed by the Administrator in the absence of the MDS Coordinator. When an MDS Coordinator is in place,</p>		

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	<p>any care plan meetings.</p> <p>Review of a current facility policy dated June 2004, titled "Nursing Policy &amp; Procedures", which was provided by the Director of Nursing on 8/1/12 at 10:30 a.m., indicated the following:</p> <p>"All disciplines involved in providing services to residents must attend care plan conferences to coordinate care and develop each resident's care plan."</p> <p>3.1-35(g)(2)</p>		<p>he/she will take over the responsibility for creating the care plan conference schedule. The Administrator will also be given a copy so that he/she can be assured that all disciplines are included in the care plan conference.</p> <p>The Designee will audit the care plan conference sign in sheet weekly for 60 days following each care plan conference to ensure that members of the interdisciplinary team have participated in the care plan conferences. The Designee will report the results of those audits to the Administrator.</p> <p>If the Administrator or Designee identifies any issues, the Administrator will address them as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Administrator or Designee will bring the results of the care plan conference audits to the monthly QA&amp;A committee for</p>	

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			further review and recommendation. This will continue for 60 days and once 100% compliance has been obtained the Committee members may decide to terminate the need for the written audit. However, the MDS Coordinator or Designee will continue monitoring the attendance at the care plan conferences on an ongoing basis. <u>Date of Compliance: 9/5/12</u>	

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F0323 SS=E	<p>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, interview and record review, the facility failed to maintain hot water temperatures at a safe temperature in 4 of 16 resident rooms (rooms 6, 8, 14 and 15), which affected 8 of 30 residents.</p> <p>Findings include:</p> <p>1. During resident observations, the hot water temperatures at the sink in the following residents' rooms were greater than 120 degrees Fahrenheit:  Room 6, on 7-30-2012 at 4:03 p.m., the hot water measured 125.8 degrees Fahrenheit;  Room 8, on 7-30-2012 at 12:02 p.m., the hot water measured 122.0 degrees Fahrenheit;  Room 14, on 7-30-2012 at 4:34 p.m., the hot water measured 124.7 degrees Fahrenheit and  Room 15, on 7-30-2012 at 4:27 p.m., the hot water measured 124.7 degrees Fahrenheit.</p> <p>On 7-30-2012 at 4:45 p.m., the Environmental Director (E#10) was</p>	F0323	<p>F323 It is the policy of this facility to ensure that the resident environment remains free of accident hazards, including providing water at temperatures that are safe for the residents. <u>1. What corrective action will be done by the facility?</u> The maintenance director has been re-instructed as to the facility policy for safe water temperatures for resident use. The maintenance director will continue to monitor the temperatures during each tour of duty as per facility policy. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected, although no residents were identified as being affected by this practice. If the maintenance director finds that water temperatures do not meet the safe temperatures outlined in the facility's policy, he will notify the Administrator immediately. Once that is done, the Administrator and maintenance director will notify other staff members so that water use will be restricted until appropriate</p>	08/06/2012			

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	<p>notified of the hot water temperatures of the above residents' rooms.</p> <p>On 7-30-2012 at 4:50 p.m., in an interview just prior to the Environmental Director re-checking water temperatures in the residents' rooms, the Environmental Director indicated he turned down the temperature of the hot water heater. E#10 indicated the mixing valve was replaced 4 months ago and it was cleaned monthly. E#10 indicated the facility policy states hot water temperatures should be between 100 and 110 degrees Fahrenheit, but the hot water temperatures usually range from 105 to 115 degrees Fahrenheit.</p> <p>On 7-30-2012 from 4:50 p.m. through 5:14 p.m., an observation with E#10 measuring water temperatures for the resident rooms included results ranging from 107.7 to 118.2 degrees Fahrenheit.</p> <p>On 8-1-2012 at 1:25 p.m., review of the Water Temperatures facility policy indicated "the hot water for all bathing and hand-washing facilities in resident care areas at the point of use, be maintained between one hundred degrees Fahrenheit (100) and one hundred ten degrees Fahrenheit (110), for the safety of the</p>		<p>water temperatures can be obtained. Once the residents are safe, the maintenance director will determine the cause of the abnormal water temperatures and make sure that the circumstances causing those temperatures are repaired or replaced. When that is completed and the maintenance director has rechecked the temperatures to make sure they are safe, he will notify the Administrator and staff that normal resident water use can occur. <u>4. What measures will be put into place to ensure this practice does not recur?</u> The maintenance director will monitor and record water temperatures as per facility policy during each tour of duty. If the temperatures are found to be out of acceptable range, he will report those results to the Administrator immediately and proceed as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The maintenance director will log water temperatures during rounds on each tour of duty following facility policy to ensure that the water temperatures are within acceptable parameters. He will review the water temperatures with the Administrator at the next scheduled morning management meeting which is held at least 5 days a week if they are within acceptable range. If not, he will</p>				

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	residents..."  3.1-19(r)(1) 3.1-19(r)(2)		proceed as in question #2. The maintenance director will review the water temperature log results at the monthly QA&A committee meeting for further recommendation for improvement. This will continue on an ongoing basis. <u>Date of compliance: 7/31/2012</u>		

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free from a significant medication error in the administration of insulin, for 1 of 1 resident reviewed regarding a medication error in a sample of 10 residents reviewed for unnecessary medications (Resident #28).</p> <p>Findings include:</p> <p>1. Resident #28's clinical record was reviewed on 8/2/12 at 9:49 a.m. Resident #28's diagnoses include but not limited to, schizophrenia, atrial fibrillation, hypertension, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and diabetes.</p> <p>A review of current physician's order indicated an original order for Levemir Flexpen (insulin), inject 42 units subcutaneous every morning for diabetes mellitus, give within 1 hour prior or 1 hour after scheduled meal. The order also included, Novolog Flexpen, use per sliding scale before meals and at bedtime. Inject subcutaneous 1 unit for blood sugars</p>	F0333	<p><u>F333</u> It is the policy of this facility for residents to receive prescribed medications as ordered by the physician. <u>1. What corrective action will be done by the facility?</u> The charge nurse responsible for the error immediately notified the Director of Nursing and attending physician. The resident was assessed and family was notified. The charge nurse responsible completed the nurse competency check offs, including review of the facility policy that the medication label is to be reviewed 3 times before administering the medication on 4/28/12 in the presence of the Director of Nursing which included observation of insulin administration. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents receiving insulin have the potential to be affected. No other residents were found to be negatively affected. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The nurse responsible for the medication error completed competency check offs on 4/28/12. The medication cart was rearranged on 8/16/12 to allow</p>	09/05/2012	

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	<p>121-150, 2 units 151-200, 3 units 201-250, 4 units 251-300, 6 units 301-350, call physician if blood sugar less than 60 or greater than 350. Give within 1 hour prior to or 1 hour after scheduled meal time and bedtime.</p> <p>A medication error report provided by the Director of Nursing (DoN) was reviewed on 8/2/12 at 10:15 a.m., which included the medication, Novolog, given in error on 4/23/12 by RN #1 to Resident #28.</p> <p>A review of a 4/23/12 facility "Incident Report" provided by the DoN, indicated the following: Resident #28's blood sugar was 131 at 7:30 a.m. The resident received 42 units Novolog instead of the one unit ordered.</p> <p>A review of nursing notes on 8/2/12 at 11:00 a.m., indicated the resident's blood sugar was 81 mg/dL at 9:00 a.m., physician was notified and new orders received to give Resident #28 additional juice and snacks. At 9:30 a.m., Resident #28's blood sugar was 77 mg/dL. At 10:00 a.m., Resident #28's blood sugar was 45 mg/dL. Physician was notified and orders to send resident to the hospital for evaluation and treatment was</p>		<p>easier identification of insulin types, and charge nurses were alerted to the insulin storage change. The Director of Nursing or Designee will complete random insulin administration observations including verbal clarification by each nurse on insulin types and actions, as well as knowledge that the medication label is to be checked 3 times before administration. The DON or designee will review the insulin administration procedure and return demonstration on all shifts with all nurses, regardless of whether or not they are currently giving insulin to residents. This will be completed three times a week for 30 days and then weekly for 30 days to make sure that the nurses are following facility policy. If any issues are identified, the Director of Nursing will stop the administration of medication at that time. She will review the facility policy regarding administration of medications and insulin with the nurse involved. The nurse will be asked to demonstrate her knowledge and competence successfully before being allowed to administer the medication/insulin to the resident. The DON will render progressive discipline for continued noncompliance. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the insulin</p>		

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	<p>received. Resident #28 was transported to hospital at 10:55 a.m.</p> <p>During review of hospital records on 8/2/12 at 11:30 a.m., the residents blood sugar was 92 mg/dL at 11:29 a.m., 111 mg/dL at 1:06 p.m., and 157 mg/dL at 2:48 p.m. The record also indicated Resident #28 remained alert and cooperative with an affect that was calm. The resident was released back to the facility and returned at 4:19 p.m.</p> <p>The facility followed their policy and procedure for the investigation of significant injuries, which included but was not limited to:</p> <p>a.) Assessment of Resident #28 was completed. No injuries noted.</p> <p>b.) Physician was notified and new orders were received.</p> <p>c.) Family was notified of incident.</p> <p>d.) Staff member involved was interviewed.</p> <p>e.) Staff member completed nurse competency check offs on 4/28/12.</p> <p>During an interview on 8/2/12 at 3:10 a.m., RN #1 indicated she had given</p>		<p>administration audits to the QA&amp;A committee at the monthly meeting for review and recommendation for the next 60 days. Once 100% compliance is attained, further audits will be completed at the discretion of the QA&amp;A committee. Even when the QA committee agrees to discontinue the monitoring of the POC, the DON or Designee will monitor the insulin medication administration competency for each nurse every 6 months. The DON will report the results of the monitoring and will rely on the QA committee for further recommendations at that time for process improvement.</p> <p><u>Date of Compliance: 9/5/12</u></p>		

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	<p>Resident #28, 42 units of Novolog (a fast-acting meal time insulin) rather than 42 units of Levemir (a long acting insulin). She immediately reported the incident to the DON. Physician was notified and new orders were received to give Resident #28 extra food for breakfast and check blood sugar levels every 30 minutes and to call physician if blood sugar drops below 100 mg/dL.</p> <p>Review of a current facility policy dated June 2004, revised 2/12, titled "Medication-General Policies", which was provided by the Director of Nursing on 8/3/12 at 2:30 p.m., indicated the following:</p> <p>"Read the label three times before administering the medication: First, when comparing the label with the MAR, second, when pulling up the medication, and third, when preparing to administer the medication to the resident."</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>			

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F0465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to keep the air conditioning/heating vents free from dust and dirt for 3 of 16 rooms (rooms 14, 15, and 17) which affected 6 of 30 residents; failed to keep windows free from dirt and cloudiness for 3 of 16 rooms (room 6, 8 and 9) which affected 6 of 30 residents and failed to complete the baseboard installation in the rooms for 3 of 16 rooms (room 8, 14 and 16) which affected 6 of 30 residents.</p> <p>Findings include:</p> <p>1. During observations, the following air conditioning/heating vents had dust accumulated on them in the following rooms: Room 14 on 7-31-2012 at 10:27 a.m. Room 15 on 7-31-2012 at 10:31 a.m. Room 17 on 7-31-2012 at 1:43 p.m.</p> <p>2. During observations, the following room windows were identified as</p>	F0465	<p><u>F465</u> It is the policy of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public including maintaining the cleanliness of the air conditioning/heating units and the windows, and maintaining the integrity of the rooms with baseboard installation. <u>1. What corrective action will be done by the facility?</u> The A/C vents in rooms 14, 15, and 17 have been taken out and power washed by the maintenance director. The Windows in rooms 6, 8, and 9 will be cleaned to remove the cloudiness by 9/5/12. If the cloudiness in the windows cannot be removed, then they will be replaced. The baseboard installation will be completed in rooms 8, 14, and 16 by 9/5/12. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected; however, no residents were negatively affected. The facility maintenance director</p>	09/05/2012

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	<p>being dirty, cloudy and difficult to see through: Room 6 on 7-31-2012 at 8:45 a.m. Room 8 on on 7-30-2012 at 11:58 a.m. Room 9 on 7-30-2012 at 11:41 a.m.</p> <p>3. During the observations, the following rooms had missing baseboards: Room 8 7-30-2012 11:58 a.m. Room 14 7-31-12 10:27 a.m. Room 16 7-31-12 10:34 a.m.</p> <p>On 8-1-2012 at 1:25 p.m., the Environment Director (E#10) provided the daily cleaning schedule for the housekeeper duties. The schedule of cleaning duties for resident rooms indicated an itemized list of duties which included "...17. A/C units clean...."</p> <p>On 8-1-2012 from 2:20 p.m. - 3:00 p.m. during the environmental tour with the Environment Director (E#10), the Environment Director indicated the air conditioning/heating vents are removed and cleaned outside with a power sprayer on a monthly basis. No further documentation was provided on a cleaning schedule for the vents.</p>		<p>will survey the facility weekly to identify other rooms that may be affected by these same or similar conditions. He will review his findings with the Administrator at the next morning management meeting which occurs at least 5 days a week. If a problem is observed, the maintenance director will notify the Administrator immediately so that the issue can be corrected as quickly as possible.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u> In addition to the rounds made by the maintenance director, the Administrator will check the condition of the physical environment throughout the facility as part of his routine daily rounds. If he observes any issues, he will relay them to the maintenance director as soon as possible. The maintenance director will proceed as outlined in question #2. If the Administrator finds continuing issues that have not been repaired or replaced effectively, he will notify the maintenance director immediately and closely monitor the repair until it is satisfactorily completed.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator and maintenance director will report the results of their rounds and</p>				

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	<p>On 8-1-2012 from 2:20 p.m. - 3:00 p.m. during the environmental tour with the Environment Director (E#10), the Environment Director indicated the windows cannot be cleaned as the substance making the windows look dirty and cloudy will not come off.</p> <p>On 8-1-2012 from 2:20 p.m. - 3:00 p.m. during the environmental tour with the Environment Director (E#10), the Environment Director indicated the residents rooms were undergoing remodeling since January 2012 and the baseboards had not been done. The Environment Director gave no indication when the baseboard installation would be completed.</p> <p>3.1-19(f)</p>		<p>checks to the QA&amp;A committee at each monthly meeting for further review and recommendations for process improvement. Any recommendations will be followed up by the maintenance director who will report the results at the next scheduled QA&amp;A meeting. The facility maintenance review will be completed as part of the ongoing preventive maintenance program.</p> <p><u>Date of compliance: 9/5/12</u></p>		