

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
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F 0000 Bldg. 00	<p>This visit was for an Initial Certification and State licensure Survey.</p> <p>Survey dates: June 15, 2015</p> <p>Facility number: 013452 Provider number: N/A AIM number: N/A</p> <p>Census bed type: SNF: 2 Total: 2</p> <p>Census payor type: Other: 2 Total: 2</p> <p>Sample: 2</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This Plan of Correction represents the Facility's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana Department of Public Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies.</p> <p>This Plan of Correction is prepared and/or executed solely because it is required by the provision of the Federal and State law.</p>	
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's</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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	<p>legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to notify a resident's Physician in a timely manner, related to a open area on the skin, for 1 of 2 resident's reviewed for Physician notification in a total sample of 2. (Resident #2)</p> <p>Finding includes:</p>	F 0157	<p>F 157 SS= D 1. Corrective action which will be accomplished for those resident(s) affected by the deficient practice: Ø R2, R2 Physician and R2 son have been notified of change in patient condition. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Ø Chart reviews were</p>	06/29/2015

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	<p>Resident #2's record was reviewed on 06/15/15 at 9:40 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and hypertension.</p> <p>A Skin Event form, dated 06/14/15 at 3:40 p.m., indicated the resident was observed with a 0.8 cm (centimeter) by 0.8 cm open area with excoriation to the surrounding area on the right buttock.</p> <p>During an interview on 06/15/15 at 10:13 a.m., LPN #1 indicated there were no calls out to the residents' Physicians. LPN #1 indicated nothing had occurred with the residents' on the Unit to notify a Physician. LPN #1 indicated she was informed in report, Resident #2 had a new open area but she had not seen the area. LPN #1 indicated there had not been an assessment of the area completed this morning because she had not seen the area.</p> <p>During an observation on 06/15/15 at 10:18 a.m., with LPN #1 present, the resident had a small superficial open area to the right inner buttock. LPN #1 indicated when she had came in to see the resident earlier, the resident was on the toilet and she had not seen the open area.</p> <p>During an interview on 06/15/15 at 10:56 a.m., the ADoN (Assistant Director of</p>		<p>conducted on the two residents in the facility for change in condition and MD notification. 3. Measures the facility will take or system the facility will alter to ensure that the problem will be corrected: Ø Nurses have been informed and educated regarding MD Notification and Change in Resident Condition. Ø Individual focused education and training was provided to the nurse(s) that identified the change in condition in R2. 4. The facility has developed a Quality Assurance Audit Tool to monitor for compliance: Ø A Quality Assurance tool has been developed to ensure that any change in patient condition will be documented and the physician will be notified. DON or designee will conduct quality assurance monitor three (3) times per week for four (4) weeks and weekly for six (6) months. All findings will be reported in our monthly QA meeting. 5. Date of Completion: 6/29/2015</p>	

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	<p>Nursing) indicated she was going to go assess the open area and then notify the resident's Physician.</p> <p>A Skin Event form, dated 06/15/15 at 1:43 p.m., indicated the right buttock open area was a reddened area without drainage or odor, and had 100% pink tissue, and the resident's Physician had been notified.</p> <p>A Physician's Order, dated 06/15/15, indicated an order for Zinc Oxide 16% (barrier cream) twice daily to the right buttock ulceration.</p> <p>During an interview on 06/15/15 at 3:38 p.m., the ADoN indicated the area looks like the area was caused by rubbing from the brief when the resident was trying to get out of the chair. The ADoN indicated she was not sure if the open area was a pressure sore or if it was from incontinence. The ADoN indicated the Nurse who had found the open area should have notified the Physician.</p> <p>A facility policy, dated 07/14, titled, "Skin Care Prevention", received from the ADoN on 06/15/15 at 12:37 p.m. as current, indicated, "...Dependent residents will be assessed during care for any changes in skin condition including redness...and this will be reported to the</p>			

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F 0314 SS=D Bldg. 00	<p>nurse. The nurse is responsible for alerting the Health Care Provider...All residents will be evaluated daily for changes in their skin condition..."</p> <p>A facility policy, dated 07/14, titled, "Physician Notification", received from the ADoN on 06/15/15 at 12:37 p.m. as current, indicated, "...In an non-emergent, but acute medical situation the physician will be paged..."</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident who entered the facility did not develop a pressure sore related to a resident acquiring a stage 2 (partial thickness skin loss. The ulcer is</p>	F 0314	<p>F 314 SS = D 1. Corrective action which will be accomplished for those resident(s) affected by the deficient practice: Ø R2's physician was notified of skin breakdown and an individualized treatment plan was created and</p>	06/29/2015

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	<p>superficial and presents clinically as an abrasion, blister, or shallow crater) pressure ulcer for 1 of 2 residents reviewed for skin concerns, in a total sample of 2. (Resident #2)</p> <p>Finding includes:</p> <p>Resident #2's record was reviewed on 06/15/15 at 9:40 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and hypertension.</p> <p>The Admission Clinical with Braden Scale form, dated 06/09/15 at 3:35 p.m., indicated the resident was at risk for a pressure sore with a score of 17 on the Braden scale, had no open areas, rash, or redness of the skin, was frequently incontinent of bladder (daily with some control present), skin was constantly moist (dampness detected every time resident is moved or turned), during a move skin probably slides to some extent against sheets or chair, and required limited assistance of one person for bed mobility.</p> <p>A care plan, dated 06/11/15, indicated the resident was at risk for alteration of skin integrity related to decreased mobility and incontinence. The interventions included, but were not limited to, pressure relief measures encouraging</p>		<p>implemented. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Ø Will perform a comprehensive review of medical record to determine any predisposing factors. Ø A risk-assessment for pressure ulcers will be performed on every resident upon admission along with a body check for pre-existing ulcers. Ø An individualized care plan will be constructed for all residents at risk and those who have ulcers.</p> <p>1.Measures the facility will take or system the facility will alter to ensure that the problem will be corrected: Ø Nursing staff educated on skin care prevention, pressure ulcer treatment guidelines, and pressure ulcer identification and staging. Ø DON or designee will review dashboard in PCC daily for alerts of any new or change in resident skin condition. Ø 1:1 counseling conducted with staff members that may be identified as not following facility guidelines for skin monitoring, assessing, and care.</p> <p>1.The facility has developed a Quality Assurance Audit Tool to monitor for compliance: Ø A Quality Assurance tool has been developed to ensure that all residents assessed to have risk for skin alteration have preventative measures in their plan of care. Ø DON or</p>				

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	<p>frequent repositioning, increased hygiene, incontinent/peri care with barrier ointment, and reinforce toileting schedule.</p> <p>A care plan, dated 06/12/15, indicated the resident was incontinent of urine. The interventions included, but were not limited to, offer toilet with rounds and as needed and on 06/14/15 voiding/incontinence tracking was initiated.</p> <p>An Incontinent tracking form, indicated the resident was checked three times on 06/10/15 and was incontinent twice, was checked three times on 06/11/15 and was incontinent once, was checked twice on 06/12/15 and was continent, was checked three times on 06/13/15 and was incontinent three times, was checked three times on 06/14/15 and was incontinent twice.</p> <p>A Nurses' Progress Note, dated 06/11/15 at 1:33 p.m., indicated the resident was incontinent of bladder.</p> <p>A Nurses' Progress Note, dated 06/14/15 at 10 a.m., indicated the resident was incontinent of bowel and bladder, and frequent toileting was encouraged to reduce skin breakdown related to incontinence.</p>		<p>designee will conduct quality assurance monitor three (3) times per week for four (4) weeks and weekly for six (6) months. All findings will be reported in our monthly QA meeting. 5. Date of Completion: 6/29/2015</p>				

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	<p>A Skin Event form, dated 06/14/15 at 3:40 p.m., indicated the resident was observed with a 0.8 cm (centimeter) by 0.8 cm open area with excoriation to the surrounding area on the right buttock.</p> <p>During an interview on 06/15/15 at 10:13 a.m., LPN #1 indicated there were no calls out to the residents' Physicians. LPN #1 indicated nothing had occurred with the residents' on the Unit to notify a Physician. LPN #1 indicated she was informed in report, Resident #2 had a new open area but she had not seen the area. LPN #1 indicated there had not been an assessment of the area completed this morning because she had not seen the area. LPN #1 indicated the resident was continent during the day hours.</p> <p>During an observation on 06/15/15 at 10:18 a.m., with LPN #1 present, the resident had a small superficial open area to the right inner buttock. LPN #1 indicated when she had came in to see the resident earlier, the resident was on the toilet and she had not seen the open area.</p> <p>During an interview on 06/15/15 at 10:56 a.m., the ADoN (Assistant Director of Nursing) indicated she was going to go assess the open area and then notify the resident's Physician.</p>			

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	<p>A Skin Event form, dated 06/15/15 at 1:43 p.m., indicated the right buttock open area was a reddened area without drainage or odor, and had 100% pink tissue, and the resident's Physician had been notified.</p> <p>A Physician's Order, dated 06/15/15, indicated an order for Zinc Oxide 16% (barrier cream) twice daily to the right buttock ulceration.</p> <p>During an interview on 06/15/15 at 3:38 p.m., the ADoN indicated the area looks like the area was caused by rubbing from the brief when the resident was trying to get out of the chair. The ADoN indicated she was not sure if the open area was a pressure sore or if it was from incontinence. She indicated Resident #2 was very active.</p> <p>An undated facility policy, titled, "Skin Management: Pressure Ulcer Treatment Guidelines", received from the ADoN on 06/15/15 at 12:37 p.m. as current, indicated, "...Treatment guidelines for at Risk Individuals...Moisture: avoid prolonged periods of wetness..."</p> <p>3.1-40(a)(1)</p>			

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F 0315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure a resident who was incontinent of urine received the appropriate treatment and services ,related to not evaluating a resident for an individualized toileting schedule as care planned for 1 of 1 resident reviewed for incontinence in a total sample of 2. (Resident #2)</p> <p>Finding includes:</p> <p>Resident #2's record was reviewed on 06/15/15 at 9:40 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and hypertension.</p> <p>The Admission Clinical with Braden Scale form, dated 06/09/15 at 3:35 p.m., indicated the resident was frequently incontinent of bladder (daily with some control present).</p>	F 0315	<p>F 315</p> <p>SS = D</p> <p>1. Corrective action which will be accomplished for those resident(s) affected by the deficient practice:</p> <p>Ø R2 started on a three day incontinence evaluation for individualized treatment and services to achieve and maintain as much normal urinary function as possible.</p> <p>-</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:</p>	06/29/2015

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	<p>A Bowel and Bladder Form, dated 06/09/15 at 6:20 p.m., indicated resident voided appropriately without incontinence less than daily, required assistance to get to the bathroom, was forgetful but would follow commands, was usually aware of the need to toilet, and had overflow incontinence (occurs when the bladder is distended from retention). The interventions recommended included a seven day elimination pattern and bladder rehabilitation/retraining.</p> <p>A care plan, dated 06/11/15, indicated the resident was at risk for alteration of skin integrity related to decreased mobility and incontinence. The interventions included, but were not limited to, incontinent/peri care with barrier ointment (house ointment), and reinforce toileting schedule.</p> <p>A care plan, dated 06/12/15, indicated the resident was incontinent of urine. The interventions included, but were not limited to, offer toilet with rounds and as needed and on 06/14/15 voiding/incontinence tracking was initiated.</p> <p>An Incontinent tracking form, indicated the resident was checked at the following</p>		<p>Ø Patients experiencing urinary incontinence will undergo a three day incontinence evaluation to better individualize their treatment plan.</p> <p>1.Measures the facility will take or system the facility will alter to ensure that the problem will be corrected:</p> <p>Ø Nursing staff will be educated on incontinence evaluation and management.</p> <p>1.The facility has developed a Quality Assurance Audit Tool to monitor for compliance:</p> <p>Ø A Quality Assurance tool has been developed to ensure that all residents assessed to have urinary incontinence have an individualized treatment plan. This will be conducted by the DON or designee on all newly admitted patients.</p> <p>5. Date of Completion: 6/29/2015</p>				

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	<p>times:</p> <p>06/10/15- 6:50 a.m.-incontinent, 2:59 p.m.-continent, 10:59 p.m.-incontinent</p> <p>06/11/15- 6:35 a.m.-incontinent, 2:59 p.m.- continent, 10:59 p.m.-continent</p> <p>06/12/14- 6:50 a.m.-continent, 11:28 a.m.-continent</p> <p>06/13/15- 8 a.m.- incontinent, 1:50 p.m.- incontinent, 6:30 p.m.- incontinent</p> <p>06/14/15- 5:50 a.m.- incontinent, 11:30 a.m.- continent, 3:40 p.m.-incontinent</p> <p>06/15/15- 6:24 a.m.- incontinent</p> <p>A Nurses' Progress Note, dated 06/11/15 at 1:33 p.m., indicated the resident was incontinent of bladder.</p> <p>A Nurses' Progress Note, dated 06/14/15 at 10 a.m., indicated the resident was incontinent of bowel and bladder, and frequent toileting was encouraged to reduce skin breakdown related to incontinence.</p> <p>During an interview on 06/15/15 at 10:13 a.m., LPN #1 indicated the resident was continent during the day hours.</p> <p>During an interview on 06/15/15 at 10:38 a.m., the ADoN (Assistant Director of Nursing) indicated there had not been a voiding pattern completed on the resident. She indicated the toilet schedule needs, "addressed".</p>			

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	<p>During an interview on 06/15/15 at 3:38 p.m., the ADoN indicated she thought the Incontinence/Continence Form was the seven day elimination pattern to individualize the resident's voiding pattern. The ADoN acknowledged the resident was only monitored 2-3 times a day for incontinence.</p> <p>A facility policy, dated 07/14, titled, "Incontinence Care", received from the ADoN as current on 06/15/14 at 12:37 p.m., indicated, "...Incontinent residents are evaluated for a bowel and bladder program and placed on one if appropriate..."</p> <p>A facility policy, dated 05/14, titled, "Bowel and Bladder Retraining", received from the ADoN as current on 06/15/15 at 1:28 p.m., indicated, "To establish regularity of bowel and bladder function for the incontinent resident...An initial bowel and bladder observation is done on all new admissions and updated quarterly. 2. After the observation the Rehab Nurse in conjunction with the Interdisciplinary Team makes a recommendation for a bowel and/or bladder retraining program...Toilet resident every 2-3 hours or as needed...Program should be documented on care plan..."</p>			

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NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
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F 0431 SS=D Bldg. 00	<p>3.1-41(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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</p>			

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	<p>dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's medication was labeled with a resident's name, route of administration, and Physician's name, and failed to ensure a resident's medication was stored securely in a locked storage area, for 2 of 2 residents reviewed for medication in a total sample of 2. (Residents #1 and #2)</p> <p>Findings include:</p> <p>1. During an observation of the Medication Cart on the C-Unit, with LPN #1 present, on 06/15/15 at 9:02 a.m., there was a bottle of Vitamin B-12 with no Pharmacy label and no resident's name on the bottle.</p> <p>LPN #1 indicated the Vitamin B-12 belonged to Resident #2.</p> <p>Resident #2's record was reviewed on 06/15/15 at 9:40 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and hypertension.</p> <p>The Physician's Order, indicated an order for B-12 tablet every morning, start 06/10/15.</p> <p>2. During an observation on 06/15/15 at 9:02 a.m., with LPN #1 present, there</p>	F 0431	<p>F 431 SS = D The facility ensures that each resident has</p> <p>1. Corrective action which will be accomplished for those resident(s) affected by the deficient practice: Ø R1 and R2's medications have been labeled and properly stored. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Ø Medication storage areas have been checked to ensure all medications have been stored and labeled properly for the two residents residing in the facility. 3. Measures the facility will take or system the facility will alter to ensure that the problem will be corrected: Ø Educate nursing staff on accepting properly labeled medications, requirements for labeled medications and storage. 4. The facility has developed a Quality Assurance Audit Tool to monitor for compliance: Ø A Quality Assurance tool has been developed to ensure that medications are properly labeled and stored. This will be completed by the DON or designee three (3) times per week for four (4) weeks and weekly for six (6) months. All findings will be reported in our monthly QA meeting. 5. Date of Compliance: 6/29/2015</p>	06/29/2015			

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	<p>were 2 containers with individual areas, with each area marked with a day of the week. There were medications in each individual area. There was no label to indicate what medications were stored in the containers.</p> <p>During an interview at the time of the observation, LPN #1 indicated medications belonged to Resident #1 and the resident self-administered her own medication. LPN #1 indicated she had sat with the resident when the resident brought the medication bottles to the Nurses' Station and set up her medications for the week. LPN #1 indicated she was unsure where the resident stored the bottles of the medication. LPN #1 indicated to her knowledge the medication bottles were not locked up.</p> <p>During an interview on 06/15/15 at 9:58 a.m., the ADoN (Assistant Director of Nursing), indicated the Nurse had been with the resident while the resident had set up her own medications per the Physician's Orders. The ADoN indicated the medication bottle may be in the resident's apartment on the upper level of the facility. She indicated she was unsure where the medications were stored.</p> <p>During an interview on 06/15/15 at 1:54</p>			

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F 0456 SS=D	<p>p.m., the ADoN indicated the resident had stored the medication in her room on the C-Unit in an unlocked closet. She indicated the facility was in the process of obtaining locked boxes for the medication.</p> <p>A facility policy, dated 09/01/15, titled, "Medication Storage", and received from the ADoN as current, indicated, "...medications will be stored under conditions that are appropriate for that item, for safety and within regulatory guidelines...Biologicals shall be labeled per physician's order..."</p> <p>A facility policy, dated 06/15, titled, " Self Administration of Medications and Treatments", received as current from the ADoN on 06/15/15 at 1:58 p.m., indicated, "...Medications and treatments for self administration are kept in a locked drawer/box in the resident room..."</p> <p>3.1-25(k) 3.1-25(m)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE</p>						

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Bldg. 00	<p>OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observation and interview, the facility failed to ensure equipment was in safe operating condition, related to an accumulation of lint in 2 of 2 clothes dryers, for 1 of 1 resident laundry room.</p> <p>Finding includes:</p> <p>During the environmental tour of the facility on 06/15/15 from 12:45 p.m. through 1:08 p.m. with the Maintenance Director and the Housekeeping Director, there was a large amount of lint accumulation in the bottom of both industrial clothes dryers, located in the Clean Laundry Room.</p> <p>During an interview at the time of the observation, the Maintenance Director indicated they were to empty the lint traps every day and check the traps at least every three hours. He indicated the staff had not been documenting when the lint traps were cleaned and/or checked.</p> <p>At the time of the Exit Conference on 06/15/15 at 4:30 p.m., the facility had not provided a copy of a policy for cleaning of the lint traps for the clothes dryers.</p>	F 0456	<p>F 456 SS = D 1. Corrective action which will be accomplished for those resident(s) affected by the deficient practice: Ø All lint traps were immediately cleaned. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Ø An audit of all other lint traps in the facility was completed. 3. Measures the facility will take or system the facility will alter to ensure that the problem will be corrected: All housekeeping and laundry staff have been inserviced regarding proper lint trap cleaning procedure and a lint trap checklist has been posted at all dryers in the facility. Lint traps will be checked and cleaned prior to usage and every 2.5 hours from 7:00-17:00. 4. The facility has developed a Quality Assurance Audit Tool to monitor for compliance: The lint trap cleaning checklist will be monitored by the Director of Maintenance daily for two weeks and weekly for a period of six months. All findings will be reported in the monthly QA meeting 5. Date of Compliance: 6/29/2015</p>	06/29/2015			

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	3.1-19(bb)				