STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155458		08/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN 46322

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 3, 4, 5, 6 and 7, 2015 Facility number: 000367 Provider number: 155458 AIM number: 100289280 Census bed type: SNF/NF: 30 Total: 30 Census payor type: Medicare: 5 Medicaid: 17 Other: 8 Total: 30 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	N/A	
F 0167 SS=C Bldg. 00	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the			

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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	facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to post a sign indicating where the most recent survey results were located without residents having to ask for 1 of 1 survey books. Finding includes: Interview on 8/5/15 at 10:42 a.m., with the Resident Council President, indicated she was unaware of where the most recent Survey results were located. Observation on 8/5/15 at 10:46 a.m., indicated the survey book was located in a cabinet behind two glass doors in front of the Administrator's office. There was no sign indicating the survey book was located inside the cabinet. Interview with the Social Service Director (SSD) on 8/4/15 at 10:48 a.m., indicated there was no sign to indicate where the survey book was located. The Social Service Director looked on the back wall by the time clock and by the other entrance/exit door and there was no	F 0167	1. A sign was posted outside of the Administrator'soffice indicating the location of the survey book. 2. All residents are at risk for this deficiency. 3. All department directors will be in-serviced bythe Administrator by 9/6/15 on the location of the survey book. 4. The Administrator, or designee, will conductrandom audits weekly x 6 months to ensure placement of the survey book and the sign indicating the location of the book. 5. Findings will be reviewed by the Administratorand DON in QAPI monthly for three months and then quarterly thereafter. *Compliance will be defined as 100% audit notation of visible signage in the designated location	09/06/2015

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	sign to indicate where the survey book was located. The SSD indicated there should have been a sign posted to let residents and visitors know where the book was located without having to ask. 3.1-3(b)(1)			
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to ensure 1 of 1 residents reviewed for restraints, had a medical symptom to warrant the use of the restraint. (Resident #8) Finding includes: On 8/5/15 at 8:10 a.m. and 1:00 p.m., Resident #8 was seated in a highback wheelchair with a lap tray in place. The resident was seated upright at this time. The resident made no attempts to remove the lap tray.	F 0221	1. Restraint and Reduction Assessment will becompleted on Resident #8 and be reviewed by the physician. 2. Any resident that has a physical restraint is at risk for this deficiency (through restraint review of the entire house). At this time, both residents with restraints were reviewed and restraint assessments updated and clarified 3. The DON will be in-serviced on the Chosenrestraint guidelines by the Regional Director of Clinical Operation by 9/6/15.The DON will in-service all nurses on the Chosen restraint guidelines by	09/06/2015

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	On 8/6/15 at 10:35 a.m., 11:40 a.m., and 1:40 p.m., the resident was seated in her wheelchair with the lap tray in place. The resident was in a upright position and no attempts were made to remove the lap tray. On 8/7/15 at 8:30 a.m. and 8:43 a.m., the resident's lap tray was on top of the table in the main dining room. The resident was in her room seated in her wheelchair with no lap tray in use. The resident was seated upright at this time and made to attempts to get out of her wheelchair unassisted. The record for Resident #8 was reviewed on 8/4/15 at 3:05 p.m. The resident's diagnoses included, but were not limited to, history of left hip fracture, dementia with agitation and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 5/6/15, indicated the resident had short and long term memory problems. The MDS also indicated the resident was totally dependent on staff for transfers, had no falls since her last assessment and had a trunk restraint used daily. A Physician's order, dated 6/30/14 and listed on the August 2015 Physician's		9/6/15. 4. The DON, or designee, will conduct an audit monthly for six months to ensure facility is following Chosen restraint guidelines and reductions are performed as indicated per the Restraint andReduction Assessment with physician approval. 5. Findings will be reviewed by the Administratorand DON in QAPI monthly for three months and then quarterly thereafter. *Compliance will be defined as 100% during audit findings	

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	Order Summary (POS), indicated the resident was to have a tray table to her broda chair for poor safety awareness. The 10/28/14 Restraint and Reduction assessment, indicated the resident had a total score of "33" indicating she was a good candidate for reduction. The documented rationale on the back of the form indicated the following, "Will not reduce. Resident attempts to remove table, has previously removed seat belt, is confused and has poor safety awareness." There were no additional restraint assessments available for review. Documentation on the Restraint and Reduction assessment form indicated the restraint was to be reviewed at least quarterly. The Nursing progress notes for the dates of 1/19-8/3/15, indicated there was no documentation related to the resident trying to remove her lap tray. Interview with the Director of Nursing (DON) on 8/7/15 at 1:00 p.m., indicated the resident's lap tray had not been assessed since October 2014. She also indicated there had been no attempts at restraint reduction and there was no documentation in the progress notes to indicate the resident attempted to remove			

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	the lap tray. 3.1-26(r)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. Based on observation, record review, and interview, the facility failed to ensure Foley catheter tubing and bags were not on the floor for 2 of 3 residents reviewed for Urinary Catheter use of the 3 residents who met the criteria for Urinary Catheter use. (Residents #5 and #29) Findings include: 1. On 8/03/15 at 11:40 a.m., Resident #5 was in the dining room seated in her wheelchair. The Foley catheter bag was not attached to the cross bars of the bottom of the wheelchair and was on the	F 0315	1. Resident #5 and Resident # 29 will have theircatheters and tubing positioned in a way that they will not be in contact withthe floor at all times. 2. All residents that have a catheter in place areat risk for this deficiency (as identified through a review of the entire house for catheter usage by the DON). 3. The DON, or designee, will in-service all staffon the correct positioning of catheters by 9/6/15. 4. DON, or designee, will complete audit 3 timesper week on residents who have a catheter to ensure proper positioning for 1month, then weekly for 1 month, then monthly. 5. Findings will be reviewed by the Administratorand	09/06/2015

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	floor behind the wheelchair. On 8/04/15 at 11:00 a.m., Resident #5 was in the dining room seated in her wheel chair. The Foley catheter bag was attached to the cross bars of the bottom of the wheel chair touching the floor. On 8/05/15 at 11:29 a.m., Resident #5 was in the dining room seated in her wheel chair. The Foley catheter bag was observed attached to the cross bars of the bottom of the wheel chair touching the floor. The record for Resident #5 was reviewed on 8/05/15 at 10:41 a.m. Diagnoses included, but were not limited to, noninfectious lymphedema, dermatitis and skin maceration. The Physician's Orders, dated 1/14/15, indicated insert Foley catheter 20 french with 30 cubic centimeters (cc's), change monthly on the 14th and as needed. Interview with the Director of Nursing (DON) on 8/07/15 at 12:45 p.m., indicated Foley catheter bags and/or tubing should not touch the floor and should be connected to the highest point of the cross bars at the bottom of the resident's wheel chairs. 2. On 08/03/15 at 10:08 a.m., Resident		DON in QAPI monthly for three months and then quarterly thereafter.	

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	#29's Foley catheter bag was on the floor. On 08/03/15 at 12:35 p.m., and 3:08 p.m., Resident #29 was in her recliner chair. Her Foley catheter bag and tubing were on the floor. On 08/04/15 at 8:44 a.m., Resident #29 was in her recliner chair. At that time, her Foley catheter bag was hanging on the trash can and the bottom of the Foley bag was sitting on the floor. The record for Resident #29 was reviewed on 08/05/15 at 10:49 a.m. The resident's diagnosis included, but were not limited to, kidney failure, neurogenic bladder and history of urinary tract infection. The Physician's orders, dated 12/26/14 and listed on the August 2015 Physician's Order Summary (POS), indicated to change the Foley catheter bag as needed for leakage or occlusion and to complete Foley catheter care every shift. Interview with the Director of Nursing (DON) on 08/07/15 at 1:10 p.m., indicated she was made aware that Resident #29's Foley catheter bag was on the floor several times. She identified the bag seemed to be touching the floor, so she had the bag raised off of the floor.			

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	She indicated the Foley catheter bag should not be on the floor. She also indicated there was no facility policy available at this time regarding Foley catheter bags on the floor. 3.1-41(a)(2)			
F 0371 SS=F Bldg. 00	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 store and prepare food under sanitary conditions related to thawing foods, food opened with no date, a dirty oven hood, burned food inside the oven, and dirty transportation carts. The facility also failed to serve food under sanitary conditions related to touching the tips of the spoons and the inside of coffee cups while serving beverages to residents for 1 of 1 kitchens. Findings include: 1. On 8/3/15 at 9:10 a.m., during the Kitchen Sanitation tour, the following was observed:	F 0371	F371 What was done to correct the alleged deficiency? A. The box of raw turkey sausage was discardedalong with the contents beneath this box. B. All items identified with no date werediscarded. C. The oven hood slates were cleaned and returnedto the range hood. Additionally, thelight in the hood has been replaced and is fully functional. D. The black burned food was removed from the baseof the inside of the oven. E. The bucket of sanitation fluid was immediatelychanged to ensure 200ppm. F. All transportation carts have been fully deepcleaned, including the wheels. G. The small transportation carts were fully deepcleaned, including the wheels. H. CNA #2, #3, and #4	09/06/2015

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	A. Inside the reach in cooler there was a box of raw turkey sausages observed on the bottom shelf. There was no pan under the box and the contents inside the box had leaked through causing the cardboard box to be wet on the outside. Interview with the Dietary Food Manager (DFM) at that time, indicated the sausages should have been thawing on the pan. B. There were open containers, boxes and bags of food in the dry food storage room that were not dated. The following was observed: 1. a bag of cheerios open and no date. 2. a bottle of red wine vinegar open and no date. 3. a bottle of teriyaki sauce open and no date. 4. a box of cornbread mix open and no date. 5. two bags of noodles open and no date. 6. a bag of mashed potato buds open and no date. 7. a box of blueberry muffin mix open and no date. 8. a box of yellow cake mix open and no date. 9. a box of croutons open and no date. 10. a box of cheese cake mix open and no date.		have received inserviceeducation on sanitation and the updated policy on food service. I. An updated policy on food services has beencreated and all team members have been trained on this policy. As all residents have the potential to be affected by thisalleged deficient practice, the following have been implemented: 1. Team members have all been trained on theupdated policy for food service. 2. All dietary and food services personnel havereceived inservice education and teachable moments related to policies onsanitation, food service, and food protection practices. 3. An audit of the dietary department has been initiatedand will be completed one time per week (after stock order has been correctlyshelved) to ensure all items are labeled and dated correctly. This audit will be done weekly for threemonths and as needed thereafter. 4. A twice daily audit of sanitation buckets, fooddebris, and food safety four times per week for four weeks has been initiated. 5. A daily checklist that must be signed off toensure transportation carts are fully clean when they are returned to thekitchen has been initiated and will be reviewed on a weekly basis. 6. Ten meals per week will be recorded as havingbeen monitored to ensure all team members are following policy on food service. These meals will be	

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	11. a box of white icing mix open and no date. Interview with the DFM, indicated all the food should have been dated when they were opened. C. The oven hood slats were dirty and dusty. The light in the hood was also burned out. The DFM indicated the last time the oven hood was cleaned was in the month of 4/2015. D. There was a moderate amount of black burned food noted on the bottom of the oven. E. The sanitary bucket measured 100 parts per million (ppm). The DFM indicated the bucket should be sanitized to 200 ppm. F. The two transportation carts used to store the resident's meal trays were dirty. The wheels on the carts were dirty and greasy. G. The two small transportation carts used to serve beverages to the residents were dirty. The wheels on the carts were dirty and greasy. The current 8/2015 Food and Labeling and Dating policy provided by the DFM,		randomly selected by time of meal and over the course of a 7 day period 7. The dietary manager has been retrained onfollowing and managing these protocols. *All audits will be conducted ongoing for a total of six months or until 100% compliance has been achieved All audits will be submitted to the quality assurance andperformance improvement committee for review and processing. Date of Completion: September 3, 2015 Responsible Party: Dietary Manager and/or Designee	

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	indicated "Items that are considered perishable are dated when delivered and when the original container is opened." The current 8/2015 Cleaning and Sanitizing/Food Contact Surfaces provided by the DFM, indicated "Fill a bucket with room temperature water and pre-mixed sanitizer liquid according to manufacture directions. Achieve concentration of 200 parts per million (ppm)." The current 8/2015 Storage Procedures provided by the DFM, indicated "Meat, fish, and poultry are stored on lower shelves below fruits, vegetables, juices and breads to prevent contamination; a shallow pan is placed under to catch juices." Interview with the DFM at that time, indicated all of the above were in need of cleaning. 2. On 08/3/15 between 11:29 a.m. and 11:54 p.m., the following was observed in the Main Dining Room: At 11:29 a.m., CNA #2 was observed touching the spoon end with her bare hands prior to stirring the resident's coffee with it. At 11:40 a.m., CNA #3 was observed			

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	touching the spoon end with her bare hands prior to stirring the resident's coffee with it. At 11:54 a.m., CNA #3 was observed touching her hair then touching the spoon end with her bare hands, and preparing the resident's coffee. At 11:54 a.m., CNA #4 was observed touching the inside of the coffee cup with her bare hands while putting sugar in the cup to prepare the resident's coffee. Interview with the Dietary Food Manager on 8/5/15 at 11:20 a.m., indicated staff were not supposed to pick up the spoons with their bare hands at the spoon end and not to touch the inside of the coffee cups with their bare hands as well. Interview with the Dietary Food Manager on 08/7/2015 at 12:52 p.m., indicated that the policy was to wash their hands or use hand sanitizer after touching their hair or clothes or anything that is not sanitary. A serving policy was not available. 3.1-21(i)(2) 3.1-21(i)(3)			
F 0441 SS=E	483.65 INFECTION CONTROL, PREVENT			

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Bldg. 00	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 accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and interview, the facility failed to ensure the storage of urinals and wash basins and the storage	F 0441	1. Rooms 11B, 6, 10, 3, 15 and 17: a. Wash basins will be placed in plastic and storedin bedside table or closet. b. Denture cups	09/06/2015

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	of the ice scoop was maintained to prevent the spread of infection 1 of 1 units. Findings include: 1. Observation during the Environmental Tour, with the Maintenance Supervisor on 8/4/15 at 2:00 p.m., indicated the following: A. In room 11B the resident's urinal was hanging from the waste basket. The urinal was not contained. There was a toothbrush on the sink with the bristles touching the sink. There was a also a denture cup on the sink with the resident's dentures inside. The cup was not covered. There were two residents who resided in the room. B. In room 6, there was a wash and mouth basin stacked on top of each other on the shelf of the television stand. Both basins were not contained in plastic. There were two residents who resided in the room. C. In room 10, there was a wash basin on the floor underneath the chair. The basin was uncovered and not contained. There were two residents who resided in the room.		will be covered at all times. c. Personal items, such as toothbrushes, will beplaced in a mouth basin and plastic when not in use and stored in the bedsidetable. d. Urinals and bed pans will placed in plastic andstored in the bedside table or closet. 2. All residents are at risk for this deficiency. 3. The DON, or designee, will in-service allnursing staff on proper use and storage, pertaining to infection control, ofresident personal care items. 4. DON, or designee, will complete audit 3 timesper week on all resident's room for infection control deficits in relation topersonal care items for 1 month, then weekly for 1 month, then monthly. 5. Findings will be reviewed by the Administratorand DON in QAPI monthly for three months and then quarterly thereafter.	

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	D. In room 3, there was a fracture bed pan on the nightstand next to the bed with urine in it. The fracture pan was not covered. There was a wash basin on the floor in the bathroom and another one on the floor in the closet. Both basins were uncovered. There were two residents who resided in the room. E. In room 15, there was a pink wash basin on the floor with items inside it. The basin was not covered. There were two residents who resided in the room. F. In room 17, there was an empty urinal sitting on top of the night stand. The lid was off and it was not contained in a plastic bag. There were two residents who resided in the room. Interview with the Maintenance Supervisor at that time, indicated all of the above should have been covered and stored properly. Interview with Director of Nursing on 8/05/2015 at 1:39 p.m., indicated she would expect the wash basins and urinals to be stored in a clean plastic bag and stored in the bed side table or on top of the closet. She also indicated the facility does not have a policy regarding the storage of the wash basins and urinals.			

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	2. On 8/6/15 at 8:55 a.m., CNA #1 was observed passing ice water to the residents room by room. She was observed walking into the residents' rooms and picking up their personal cups and taking them to the ice cooler parked in the doorway. She was then observed lifting the lid of the ice cooler with her ungloved hand then placing her ungloved hand into the ice bucket. She then retrieved the plastic ice scoop with her ungloved hand from the cooler, filled the cup with ice and placed the plastic ice scoop back into the ice cooler. Interview and observation at that time with the Director of Nursing, indicated the CNA should not have placed the plastic ice scoop back into the ice cooler with her ungloved hand after entering and exiting the residents' rooms and touching various items. 3.1-18(a)			
F 0465 SS=E Bldg. 00	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 and interview, the facility failed to ensure the resident's	F 0465	F465 What was done to correct the alleged deficiency? A. The wall tile behind the dish machine	09/06/2015

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	environment was clean and in good repair related to marred walls, dirty and dingy floor tile, dirty floors, peeling baseboard, cracked floor tile, for 1 of 1 Units. The facility also failed to keep the kitchen clean related to dirty baseboards, food crumbs and dirt on the floor, cobwebs and grease on pipes and wall tile underneath the dish machine for 1 of 1 Kitchens. Findings include: 1. On 8/3/15 at 9:10 a.m., during the Kitchen sanitation tour, the following was observed: A. The wall tile behind the dish machine was dirty with dried food spillage. There was a large amount of dried food crumbs and dirt adhered to the floor along the baseboard under the dish machine. The white PVC (polyvinyl chloride) pipes were dirty under the dish machine. B. The soap dispenser was falling off of the wall. C. There were food crumbs and dirt adhered to the floor tile next to the stove. D. The gas and lighting pipes next to the stove had cobwebs and grease noted on them.		wascleaned, along with the floor, baseboard, and PVC pipe in this area. B. The soap dispenser has been replaced and is nowadhered correctly to the wall. C. The area near the stove has been deep cleaned. D. The pipes next to the stove have been cleaned. E. The back door is scheduled to be changedcompletely by September 6, 2015. F. The wood floor and walls in the dining room havebeen thoroughly cleaned. The baseboardis scheduled to be replaced by September 6, 2015. G. In room 5, the walls have been patched andpainted. The floor tile has been deepcleaned and shined. H. In room 9, the floor was thoroughly cleaned andthe walls have been patched and painted. I. In room 11, floor tile has been ordered and theroom will be retiled by September 6, 2015. J. In room 6, floor tile has been ordered and theroom will be retiled and have new cove base applied by September 6, 2015. The room has been deep cleaned. The walls have been patched and painted. K. In room 15, floor tile has been ordered and theroom will be retiled and have new cove base applied by September 6, 2015. The walls have been patched and painted. L. In room 13, the ceiling and walls have beenpatched and painted. Floor tile has beenordered and will be retiled and new cove base applied by September 6,2015. The room	

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	Interview with the Dietary Food Manager on 8/3/15 at 9:30 a.m., indicated all of the above was in need of cleaning and/or repair. 2. On 8/3/15 at 12:05 p.m., the back exit door was pushed opened and staff were observed to go out of the door. At that time, the door was observed not to close all the way and had to be manually pulled shut by the facility staff. Interview with the Maintenance Supervisor on 8/3/15 at 3:00 p.m., indicated he was aware the door did not completely close shut and the facility had bids out to fix the job, but nothing had been finalized. 3. On 8/3/16 at 12:10 p.m., during the lunch meal, the following was observed in the Main Dining Room: A. The wood floor tile was dirty and sticky when walked on. The walls were observed with a moderate amount of food and/or beverage spillage on them. There was adhered dirt and food crumbs noted along the baseboard and the baseboard was observed peeling away from the wall in several areas. 4. The Environmental tour on 8/4/15 at		has been deep cleaned. M. In room 18, the floor tile has been ordered andthe room will be retiled and new cove base applied by September 6, 2015. The walls have been patched and painted. N. In room 12, the cove base has been changed. O. In room 10, the safety skid strips have beenchanged and applied correctly. The roomwill be retiled and new cove base applied by September 6, 2015. The faceplate has been applied. The room has been patched and painted. P. In room 4, a new plastic wall guard has beensecured to the wall correctly. The floortile has been shined until it is replaced on September 6, 2015. Q. In room 1, the area surrounding the airconditioning unit has been patched and painted. R. In room 3, the walls and doors have been patchedand painted. S. In room 7, the floors were scrubbed. T. In room 14, the floor has been cleaned until newtile arrives. The room will receive newtile and cove base by September 6, 2015. As all residents have the potential to be affected by this allegeddeficient practice, the following has been put into place: 1. The maintenance coordinator, along with theentire housekeeping team, have received inservice education on appropriatemanagement of the environment (along with the facility policies as it relatesto	

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	2:00 p.m., with the Maintenance Supervisor, indicated the following: A. In room 5, the wall next to the bed was scratched and marred. The floor tile was dirty and the tile underneath the sink was dusty and dirty. There were two residents who resided in the room. B. In room 9 the floor was dirty and the walls were marred. There were two residents who resided in the room. C. In room 11 the floor tile was missing near the head of bed two. There were two residents who resided in the room. D. In room 6 the floor tile was cracked along the edges and discolored. There was a moderate amount of dust and dirt along the baseboard and inside the track of the closet door. The wall behind the beds were marred and paint chipped. There were two residents who resided in the room. E. In room 15 the floor tile was dingy and dirty. The wall was gouged behind the head of bed one. There were two residents who resided in the room. F. In room 13 there were several plaster patches on the ceiling. The floor tile was dingy and dirty. The wall in front of the		such). 2. The maintenance coordinator has receivedtraining on an updated preventative maintenance program. 3. The administrator will round and document twicedaily the environmental concerns and ensure these are addressed immediately (oras quickly as possible for large projects). These rounds will be twice daily, five days per week, for three monthsand thereafter, as needed. Compliance will be defined as 100% If compliance is not achieved at this percentage, audits will continue. 4. All residents were alerted that theenvironmental areas are being addressed and to please notify the facility ifthey have concerns. 5. All personnel have been trained on usage of the'work order' requests. All audits and rounds will be submitted to the qualityassurance and performance improvement committee for review and processing. Date of Completion: September 6, 2015 Responsible Party: Administrator and/or Designee	

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	bed was marred. The baseboard was peeling away by the closet and was dirty. There were two residents who resided in the room. G. In room 18 the floor tile was chipped and cracked. The floor tile was dingy and dirty with black scuff marks noted. The corner wall by the closet door was gouged. The wall behind the door was marred. There were two residents who resided in the room. H. In room 12 the baseboard in front of the closet was dented in. There were two residents who resided in the room. I. In room 10 the floor was dirty and dingy. The safety/skid strips were peeling from the floor near bed A. The floor tile was cracked by the sink. The floor tile was scratched in front of the dresser. The face plate was missing from an outlet behind the dresser. The walls were marred and scratched throughout the room. There were two residents who resided in the room. J. In room 4 the the plastic wall covering next to the bed was peeling at the top edge. The floor tile was dirty and dull. There were two residents who resided in the room.			

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	K. In room 1 the plaster was peeling around the base of the air conditioning unit. There was one resident who resided in the room. L. In room 3 the walls were paint chipped and marred. The closet and bathroom doors were paint chipped and marred. There were two residents who resided in the room. M. In room 7 the floors were dirty and sticky. There were two residents who resided in the room. N. In room 14 there was black scuff marks noted on the floor. The floor tile was cracked, dingy and dirty. There was one resident who resided in the room. Interview with the Maintenance Supervisor at that time, indicated all of the above areas were in need of cleaning and/or repair. 4. A confidential interview with an alert and oriented resident on 8/3/15 at 10:28 a.m., indicated the facility's floors and walls were very dirty. 3.1-19(f)			

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