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
	155361		07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBER MANOR CARE CENTER	801 E ILLINOIS ST PETERSBURG, IN 47567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 8, 9, 10, 13, 14, and 15, 2015. Facility number: 000252 Provider number: 155361 AIM number: 100267780 Census bed type: SNF: 11 SNF/NF: 36 Residential: 14 Total: 61 Census payor type: Medicare: 11 Medicaid: 31 Other: 5 Total: 47 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on July 14, 2015 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 7-31-2015 We respectfully request paper compliance.	

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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F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure services were provided to maintain the dignity of residents during dining and showers. (Resident #21, Resident #25, Resident #35, Resident #59, Resident #66, Resident #70, Resident #80, Resident #96, Resident #500). Findings include: 1. During a dining observation in the restorative dining room on 7/8/15 from 12:20 P.M., to 1:01 P.M., the following was observed: Certified Nursing Assistant (CNA) #15 was observed sitting between Resident #96 and Resident #25 who both required assistance to eat. CNA #12 was observed to be at the same table between Resident #21 and Resident #66 with their meals. During this observation CNA #15 and CNA #12 were observed to be talking between themselves and not interacting with the residents at the table.	F 0241	F 241 Residents #21,25,35,59,66,70,80,96,and 500 suffered no ill effects from the alleged deficient practice and through corrective action and in servicing will ensure the campus promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Completion Date 8-7-2015** All residents have the potential to be affected and therefore through alterations in provision of care and in servicing the campus will promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Completion Date 8-7-2015** All staff have been in serviced regarding resident's dignity during meals and dignity with bathing. Systemic change is the campus has trained all staff on how to transport a resident to the shower with dignity. The SS director will complete questionnaire on 5 residents weekly to assure	08/07/2015

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	2. Resident #59 was observed attempting to cut up and feed himself/herself during the meal. During this observation Resident #59 was observed to be dropping food into his/her lap and the wheel chair and then picking up the food with his/her fingers from the chair to eat it. During this observation no staff attempted to assist Resident #59 with his/her meal. During an interview on 7/14/15 at 09:30 P.M., CNA #17 indicated when assisting dependent residents with meals staff should be conversing with and engaging the residents and not amongst themselves. During an interview on 7/14/15 at 2:55 P.M., with the Healthcare Facility Administrator (HFA) she indicated it was the policy of the facility to ensure, all residents at the facility were treated with dignity and/or assisted with maintain their dignity. 3. During a random observation on West hall 7/8/15 at 9:35 A.M., Resident #80 was observed sitting in a white shower chair. Resident #80 was covered by a white sheet with bare feet exposed. CNA #22 was observed pushing Resident #80 to the far end of West hall to the shower room.		resident's dignity maintained. **Completion Date 8-7-2015** ED/ designee will interview 3 random residents to assure dignity and respect of the individual 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 8-7-15**	

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	4. During a random observation on West hall 7/10/15 at 9:57 A.M., Resident #70 was observed sitting in a white shower chair. Resident #70 was covered by a white sheet with bare feet exposed. CNA #20 was observed pushing Resident #70, past 2 residents, to the far end of West hall to the shower room. During an interview in the shower room with CNA #20 on 7/10/15 at 10:10 A.M., CNA #20 indicated the Hoyer lift and stand aid were used in the shower room when residents were placed in the tub for a bath. 5. During a random observation on 7/10/15 at 9:00 A.M., Resident #35 was observed to be transported through the West hall in a shower chair by CNA #10 . Resident #35 was observed, at that time, to be wrapped in a bath blanket with bare lower legs and feet exposed and to have wet hair. 6. During a random observation on 7/13/15 at 11:05 A.M., Resident #25 was observed to be pushed backwards in a shower chair through the West hall by CNA #11. Resident #25 was observed, at that time, to be covered in a bath blanket with feet and lower legs exposed. 7. During a confidential interview on 07/13/15 at 11:24 A.M., Resident #500 indicated it was a usual occurrence to be			

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	undressed in the room and be transported through the hall to the shower room with only a bath blanket for coverage. Resident #500 further indicated, after receiving a shower, it was a usual occurrence to be transported back to the room, without being dressed and to have only a bath blanket for coverage. Resident #500 then indicated it was uncomfortable to be transported through the hall in this manner. The clinical record of Resident #500 was reviewed on 7/13/15 at 11:30 A.M. and indicated Resident #500 experienced no cognitive impairment. During an interview on 07/14/15 at 3:30 P.M. the HFA (Health Facilities Administrator) indicated no policy could be provided related to Dignity, but it was the usual practice of the facility staff to provide care and services in a dignified manner. 3.1-3(t)			
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			

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	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, interview, and record review, the facility failed to ensure other interventions to treat urinary retention and supporting documentation for a diagnosis of urinary retention were in place prior to utilizing an indwelling urinary catheter. (Resident #72) Findings include: Resident #72 was observed on 7/10/15 at 9:45 A.M. Resident #72 was observed sitting in a wheel chair in his/her room. A catheter bag was observed to be hanging under the wheel chair with dark yellow urine present in the tubing. The clinical record for Resident #72 was reviewed on 7/10/15 at 10:37 A.M. The clinical record indicated Resident #72's admitting diagnoses included, but were not limited to, diabetes mellitus type 2, and overactive bladder with a diagnosis of urinary retention added 6/2/15. A physicians progress note dated 3/5/15 indicated Resident #72 had been seen by an infectious disease specialist and they	F 0315	**F 315** Resident # 72 suffered no ill effects from the alleged deficient practice.The physician has reviewed the residents chart and orders given as appropriate. **Completion Date 8-7-2015** All residents have the potential to be affected by the alleged deficient practice and therefore through corrective actions and in servicing the campus will ensure other interventions to treat urinary retention are in place prior to utiliing an indwelling catheter. The other residents in the campus have been reviewed to assure documenation is adquate for the placement of a catheter. **Completion Date 8-7-2015**	08/07/2015

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	had recommended no further antibiotics at that time as the infection was colonized (present and causing no ill effects). A "Monthly Nursing Assessment & Data Collection" form dated 5/24/15 indicated Resident #72 experienced frequent episodes of urinary incontinence related to a diagnosis of overactive bladder and was on a toileting plan. A telephone order dated 6/2/15 at 9:00 A.M included "may [sig] in/out cath [catheterize] post [after] void [urinating] to [check] for urinary retention. Anchor [brand] of catheter if > [greater than] 300 cc [cubic centimeters] obtained." A physician's progress note dated 5/14/15 indicated Resident #72 had a history of colonized urinary tract infection and was experiencing no signs and symptoms of current infection. The note continued and indicated Resident #72 was taking solifenacin 5mg a (a medication for overactive bladder) daily. A nurse's note dated 6/2/15 at 10:30 A.M., indicated a catheter had been anchored for urinary retention. The note lacked any documentation how much urine was obtained.		All nursing staff has been in serviced concerning the federal regulation for foley catheter placement. Systemic change is any catheter placed while resident is in the campus will be reviewed in morning CCM to assure proper placement criteria met. **Completion Date 8-7-2015** DHS and/or designee will monitor 1 resident with a catheter to assure federal regulation is followed with placement of catheter 5x a week x one month then 3x a week x one month then weekly thereafter with results forwarded to the QA committee for 6 months and quarterly thereafter for further review and suggestions/recommendations. **Completion Date 8-7-2015**	

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	A "ELIMINATION CIRCUMSTANCE, REASSESSMENT AND INTERVENTION" form dated 6/2/15 at 10:30 A.M., indicated Resident #72 had catheter inserted related to urinary retention and infection. The form lacked documentation of the actual amount of urine obtained. A nurses note dated 6/4/15 at 6:30 A.M., indicted a recent urinalysis revealed a colonized infection and no treatment was indicated. The care plans were reviewed and included, but were not limited to history of urinary tract infections initiated 3/10/15, the interventions included, but were not limited to, increase fluids, monitor intake and output, and toileting before and after meals. A care plan for urinary incontinence initiated 3/10/15 intervention include, but were not limited to, toileting upon rising before and after meals, every 2 hours, bedside commode for toileting, assist with incontinence care, monitor for signs and symptoms of urinary tract infection. A care plan for catheter initiated 6/9/15 included, but was not limited to,keep drainage bag below level of bladder, tubing free of kinks, and catheter care			

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	every shift. During an interview on 7/10/15 at 1:15 P.M., the Director of Nursing (DON) indicated, Resident #72 had been experiencing a urinary tract infection and incontinence since January and possibly longer. She indicated on 6/2/15 she had been assisting Resident #72 to transfer off the toilet when he/she had experienced an incontinence episode. The DON indicated she asked Resident #72 if they were emptying their bladder fully and Resident #72 indicated he/she was unsure. She further indicated based on the observation Resident #72 was catheterized for retention during which they obtained greater than 200 milliliters of urine but less than 600 milliliters. She indicated at that time there had been no attempt to remove the catheter. During an interview on 07/13/2015 at 10:00 A.M Resident #72 indicated he/she had been told he/she had the catheter in place since he/she had experienced a urinary tract infection for such a long time. Resident #72 indicated prior to the insertion of the catheter he/she had experienced no pain, discomfort, and had experienced no difficulty emptying his/her bladder but did experience incontinence prior to the insertion...			

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	A policy titled " GUIDELINES FOR THE USE OF INDWELLING CATHETER " dated September, 2014 was provided by the DON on 7/14/15 at 9:40 A.M., it included, but was not limited to " ...Urinary catheters are deemed medically necessary for the following reasons and must have a supporting diagnosis for its use... ...Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible and which is characterized by: Documented post void residual (PVR) volumes in a range over 200 milliliters (ml)... ...Inability to manage the retention/incontinence with intermittent catherterization... " During an interview with the DON 7/13/15 at 10:33 A.M., she indicated Resident #72's catheter was in place for UTI and urinary retention. She indicated Resident #72 had a colonized urinary tract infection since January and had not been able to clear up due to Resident #72's inability to empty his/her bladder. She indicated Resident #72 had been seen by an infectious disease doctor who recommended no further antibiotics. The DON further indicated at that time that Resident #72 continued to experience some symptoms of UTI for example strong smelling discolored urine but no			

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	discomfort or fever. She indicated Resident #72 recently had a urinalysis that showed a colonized infection and no treatment had been indicated at that time. 3.1-41(a)(1)			
F 0323 SS=D Bldg. 00	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 ensure adequate supervision and effective interventions were provided for 2 of 3 residents reviewed for accidents. (Resident #82, Resident #38) Findings include: 1. On 7/10/15 at 11:20 A.M., Resident #82 was observed sitting in a wheelchair at the end of the bed. At that time, Resident #82's call light was observed curled up in the middle of the bed and out of reach. On 7/14/15 at 10:43 A.M., Resident #82 was observed sitting in a wheelchair with the bedside table between the wheelchair and the bed. At that time, Resident #82's	F 0323	F 323 Resident 38 and 82 safety plans of care have been reviewed and updated as applicable. Resident #82 recieved a call light spliter. **Completion Date 8-7-2015** All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will 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. All residents who have fallen with in the last 30 days have been reviewed for appropriate interventions **Completion Date 8-7-2015** Nursing staff have been in serviced concerning fall risk assessment and fall interventions. Systemic changes are campus will review monthly	08/07/2015

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	call light was observed to be in the middle of his bed and outside of reach. During an interview with LPN #16 at that time, LPN #16 indicated Resident #82 could reach the call light, and all the resident needed to do was roll the wheelchair backwards around the bedside table and reach over the bed to get the call light. LPN #16 said, "Yes, it might take him awhile." The clinical record of Resident #82 was reviewed on 7/13/15 at 10:00 A.M. The record indicated Resident #82 was admitted on 5/13/15. The diagnoses of Resident #82 included, but were not limited to, Parkinson's with acute exacerbation, atrial fibrillation, orthostatic hypertension, and weakness secondary to urinary tract infection. An "Admission Assessment & Data Collection" form dated 5/13/15, indicated Resident #82 had the following conditions: cognitive impairment which effects safety and judgement, difficulty understanding and following directions, and a history of falls. The Admission MDS (Minimum Data Set) assessment dated 5/20/15, indicated Resident #82 experienced Parkinson's disease, cognitive impairment, balance impairment, and required the extensive		summaries in daily Clinical Care Meeting for fall risk assessment and entire medical record post fall to assure interventions effective. **Completion Date 8-7-2015** DHS /designee will monitor 3 random resident at risk for falls to assure safety interventions in place and interventions effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 8-7-2015**	

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	assist of two staff for transfers. An "Individual Plan Report" dated 5/26/15 indicated: "...I have been diagnosed with Parkinson's, an impaired central nervous system with the following symptoms: ...gait disturbances, frequent falls...difficulty changing positions or transferring..." A Care Plan "At risk for fall/injury dated 5/13/15 included, but was not limited to, interventions of: "...Call light within reach...Educate/remind resident to request assistance prior to ambulation" Intervention added on 5/19/15, "visual cue at bedside to call for assistance" Intervention added on 5/28/15, "Dycem above et [and] below seat cushion" Intervention added on 7/5/15, "Call light alert to bed pad alarm box-mesh bag for alarm box-night shift to offer to get up" Fall #1 A Fall Circumstance Assessment and Intervention Report indicated Resident #82 experienced an unwitnessed fall on 5/19/15 at 6:58 A.M. Resident #82 was found in the room, on the floor, and had fallen while transferring self. The "FALL RISK RE-ASSESSMENT" read as follows: "...Resident has cognitive or memory impairment that effects safety			

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	and judgment? Y [YES]...Resident has difficulty understanding and following directions? Y [YES]...Resident has poor, impaired vision or forgets to wear glasses? Y [yes]...Resident refuses to comply with safety measures such as call light use, alarms...? Y [yes]..." "CARE PLAN...New...Visual cue - call for assistance..." Fall #2 A Fall Circumstance Assessment and Intervention Report indicated Resident #82 experienced an unwitnessed fall on 5/28/15 at 4:30 P.M. Resident #82 was found in the room, on the floor, and had fallen while reaching for an object. The "FALL RISK RE-ASSESSMENT" read as follows: "...Resident has cognitive or memory impairment that effects safety and judgment? Y [YES]...Resident has a history of falls in the last 3 months? Y [yes]...Resident refuses to comply with safety measures such as call light use, alarms...? Y [yes]..." "CARE PLAN...Update...Dycem to Mw/ac [wheelchair] above and below seat cushion." Fall #3 A Fall Circumstance Assessment and Intervention Report indicated Resident			

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	#82 experienced an unwitnessed fall on 7/1/15 at 7:00 A.M. Resident #82 was found in the room, on the floor, and had fallen transferring self upon awakening. "...Equipment inspection: ...upon inspection @ [at] time of fall alarm box moved et [and] cord disconnected." The "FALL RISK RE-ASSESSMENT" read as follows: "...Resident has cognitive or memory impairment that effects safety and judgment? Y [YES]...Resident has a history of falls in the last 3 months? Y [yes]...Resident refuses to comply with safety measures such as call light use, alarms...? Y [yes]..." "CARE PLAN...Update...offer to get up by 0630 [6:30 A.M.], call light alarm for bed, mesh bag for for alarm box." A "FALLS MANAGEMENT PROGRAM GUIDELINES" was provided by the ADON (Assistant Director of Nursing) and reviewed on 7/14/25 at 2:55 P.M. It read as follows: "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures..." During an interview on 7/14/15 at 11:04 A.M., Occupational Therapy #1 [OT #1] indicated Resident #82 was at high risk to experience falls. The OT #1 further indicated that, due to the slower movements Resident #82 experienced,			

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	the call light needed to be immediately accessible and within easy reach. During an interview on 7/14/15 at 3:34 P.M., the Director of Nursing (DON)indicated Resident #82 was at a high risk to experience falls. The DON further indicated, at that time, the call light would be moved to a position within Resident #82's reach. 2. During an interview on 7/9/15 at 10:45 A.M., LPN #10 indicated Resident #38 had experienced a falls in June. On 7/13/15 at 11:22 A.M., Resident #38 was observed in her room sitting up in a wheel chair with eyes closed. Resident #38 was observed to have a self-releasing seatbelt in place. The clinical record for Resident #38 was reviewed on 7/13/15 at 9:49 A.M, diagnoses included, but were not limited to, dementia, and hypertension. A fall circumstance form dated 6/4/15 1935 (7:35 P.M.) included, but was not limited to, "... Found on floor ... ...Location of fall front door of building, curb area ... ...Injury location: face, hit head, laceration ... " The interventions added included, but were not limited to " ...sign placed @ [at] entrance for visitors to ask for staff assist ..., ... wander guard			

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	to w/c [wheel chair] to alert staff when res [resident] enters area [with] unlevel surface ..., ... activity staff to remain in activity area until all res retrieved by nursing ... " A "Monthly Nursing Assessment & [and] Data Collection" form dated 5/12/15 at 1:30 A.M., indicated Resident #38 experienced cognitive impairments that effect safety/judgment, and experienced difficulty understanding and following directions. The assessment further indicated Resident #38 requires assist of 1 for transfers and ambulation. The care plans were reviewed and included, but were not limited to, "I have altered cognition related to my diagnosis of dementia" initiated 6/23/15. The interventions include, but were not limited to use my name and provide me yours, introduce me to new situations gradually and with many repetitions due to my memory deficits, ask me simple yes and no questions as possible. A care plan for falls initiated 6/26/15, the interventions include, but were not limited to, remind resident and reinforce safety awareness, educate/remind resident to request assistance prior to ambulation, invite, encourage, remind, escort to activity programs consistent with			

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	resident's interests to enhance physical strengthening need, wander guard bracelet to wheel chair related to residents vision loss making him/her unable to see change in surface levels such as curbs, ramps, and add sign to lobby for visitors to check with staff prior to assisting residents outside. On 7/14/15 at 9:30 A.M., interview with Certified Nursing Assistant (CNA) #17 indicated Resident #38 was cognitively impaired and required assistance of 1 for transfers, ambulation. CNA #17 further indicated Resident #38 required frequent cuing for safety awareness. During an interview with the Director of Nursing on 7/14/15 at 10:00 A.M., she indicated Resident #38 had experienced a fall on June 4, 2015. She indicated prior to the fall Resident #38 was considered a fall risk and had safety interventions in place including, but not limited to an alarm on her bathroom door to alert staff if she attempted to use restroom and a self releasing alarming seatbelt. She indicated on 6/4/15 Resident #38, had been in an activity and following the activity went outside to sit on porch. The DON indicated Resident #38 was experiencing vision loss and was unable to see the curb and propelled his/her wheel chair off of the porch and fell. She			

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	indicted Resident #38 had a laceration to the forehead and bruising around the eyes and was sent to the local hospital for evaluation as a result of the fall. She indicated the interventions put into place were a wander guard to wheel chair to alert staff when Resident #38 was approving an unlevel surface and a sign in the front lobby to ask visitors to consult staff prior to taking residents outside. She further indicated no staff was present outside at the time of the fall. 3.1-45(a)(2)			
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 environment was sanitary and comfortable, resident rooms were not free of pervasive urine odor, bathroom lighting was not adequate, ceiling tiles were missing, and carpet had stains for 11 of 11 residents who met the criteria for review of environment on 2 of 3 nursing units. (Room #116, Room #127, Room #103, Room #104, Room #114, Room #112, Room #105, Room #107, Room #111, Resident #124)	F 0465	F 465 The campus addressed all issues noted in the 2567 odors, bathroom lighting, ceiling tiles and carpet stains. **Completion Date 8-7-2015**	08/07/2015

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	Findings include: 1. On 7/8/15 at 12:12 P.M., Room #116 was observed to have a pervasive odor of urine. On 7/10/15 at 9:02 A.M., Room #116 was observed to have a pervasive odor of urine. 2. On 7/8/15 at 12:15 P.M., Room #127 was observed to have a pervasive odor of urine and multiple carpet stains. On 7/10/15 at 9:03 A.M., Room #127 was observed to have a pervasive odor of urine and multiple carpet stains. 3. On 7/8/15 at 2:13 P.M., the bathroom of Room #103 was observed to have a missing ceiling tile. On 7/10/15 at 8:55 A.M., the bathroom of Room #103 was observed to have a missing ceiling tile and dim lighting. 4. On 7/8/15 at 2:24 P.M., Room #104 was observed to have multiple carpet stains. On 7/10/15 at 8: 58 A.M., Room #104 was observed to have multiple carpet stains.		All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. **Completion Date 8-7-2015** All items identified on the 2567 have been cleaned. All housekeeping employees have been in serviced on cleaning the floors properly realted to stains and odors. All lightbulbs in the bathrooms were changed to a higher watt. All staff in service regarding filing out work orders. Systemic change is a new carpet cleaning schedule. **Completion 8-7-2015** ED/designee will complete environmental rounds to ensure environment safe, functional, sanitary, and comfortable environment for residents 5x a week for a month then 3x a week for a month then weekly with results	

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	5. On 7/08/15 at 2:45 P.M., Room #114 was observed to have multiple carpet stains. During an interview, at that time, Resident #8 indicated the lighting in the bathroom was not adequate and further indicated sometimes the bathroom door had to be left open during use to achieve proper lighting. 6. On 7/8/15 at 2:55 P.M., Room #112 was observed to have a pervasive odor of urine. The shared bathroom of Room #112 was observed to have dim lighting, and missing ceiling tiles. On 7/10/15 at 9:00 A.M., Room #112 was observed to have a pervasive odor of urine. The shared bathroom of Room #112 was observed to have dim lighting, and missing ceiling tiles. 7. On 7/8/15 at 3:08 P.M., Room #105 was observed to have a pervasive odor of urine and multiple carpet stains. The shared bathroom of Room #105 was observed to have exposed light bulbs and no cover on the fixture. On 7/10/15 at 8:56 A.M., Room #107 was observed to have a pervasive odor of urine and multiple carpet stains. The shared bathroom of Room #107 was observed to have exposed light bulbs and		forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 8-7-2015**	

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	no cover on the fixture. 8. On 7/8/15 at 3:14 P.M., Room #111 was observed to have a pervasive urine odor and multiple carpet stains. The bathroom of Room #111 was observed to have dim lighting. On 7/10/15 at 8:59 A.M., Room #111 was observed to have a pervasive urine odor and multiple carpet stains. The bathroom of Room #111 was observed to have dim lighting. 9. On 7/9/15 at 2:04 P.M., Room #124 was observed to have a pervasive odor of urine and multiple carpet stains. On 7/10/15 at 9:04 A.M., Room #124 was observed to have a pervasive odor of urine and multiple carpet stains. During an interview on 7/10/15 at 9:05 A.M., the MS (Maintenance Supervisor) #1 indicated, the ceilings should not have missing tiles, the bathroom lighting was dim, lightbulbs should not be exposed, and light fixtures should have covers. During an interview on 7/10/15 at 9:10 A.M., the HS (Housekeeping Supervisor) #1 indicated urine odor and carpet stains were a problem in the facility. HS #1 further indicated, the facility had no			

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	specific policy related to containing odors, but it the usual facility practice to keep the facility free of odors. The Policy and Procedure for "Floor Care" provided by HS #1 on 7/10/15 at 10:00 A.M. indicated, "...5. The individuals assigned to the vacuuming duties should be carrying spot cleaner to address spots as noticed. Work orders should be generated for any location with carpet spots needing special attention We do not want to wait for the carpet cleaning schedule to address..." 3.1-19(f)			
R 0000 Bldg. 00	This visit was for the State Residential Licensure Survey. Residential Census: 14 Sample: 7 Amber Manor Care Center was found to be in compliance with 410 IAC 16.2-5, in regard to the State Residential Licensure Survey.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law.	

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			This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on July 14, 2015 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 7-31-2015 We respectfully request paper compliance.	