

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155743</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN-HILL MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 N LINCOLN AVE FOWLER, IN 47944</b>		
(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 000	<p>INITIAL COMMENTS</p> <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 15, 16, 19, and 20, 2013</p> <p>Facility number: 000288 Provider number: 155743 AIM number: 100287380</p> <p>Survey team: Regina Sanders, RN, TC Jennifer Redlin, RN Caitlyn Doyle, RN Heather Hite, RN</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census Payor type: Medicare: 5 Medicaid: 26 Other: 5 Total: 36</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 26, 2013, by Janelyn Kulik, RN.</p>	F 000			
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p>	F 241		9/6/13	

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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F 241	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure each residents' dignity was maintained related to, an uncovered indwelling urinary catheter bag for 1 of 2 residents reviewed with a urinary catheter in a total sample of 15. (Resident #14)</p> <p>Findings include:</p> <p>On 8/16/13 at 10:32 a.m., Resident #14 was observed in bed, the resident's indwelling urinary catheter drainage bag was observed uncovered and hanging from the side of the bed. The urinary catheter drainage bag was visible from the hallway.</p> <p>On 8/16/13 at 2:40 p.m., the resident was observed in bed, the resident's urinary catheter drainage bag was observed uncovered and was visible from the hallway.</p> <p>On 8/19/13 at 10:30 a.m., the resident was observed in bed, the resident's urinary catheter drainage bag was observed uncovered and was visible from the hallway.</p> <p>The record for Resident #14 was reviewed on 8/16/13 at 2:40 p.m. The resident's diagnoses included, but were not limited to, pressure ulcers and hypertension.</p> <p>Review of the current care plan, dated 7/1/13, indicated the resident required the use of a urinary catheter and was at risk for infection. The Nursing interventions indicated to keep catheter</p>	F 241			

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F 241	Continued From page 2 drainage bag covered as to maintain resident dignity and privacy.  Interview with the Corporate Nurse Consultant on 8/19/13 at 3:43 p.m., indicated the urinary catheter drainage bag should have had a dignity bag or cover in place.	F 241			
F 282 SS=D	3.1-3(t) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow a resident's physician orders and care plan, related to blood sugar monitoring for 1 of 1 residents reviewed for blood sugar monitoring in a sample of 15. (Resident #8)  Findings include:  Record review was completed for Resident #8 on 8/16/2013 at 10:00 a.m. The resident's diagnoses include, but were not limited to, diabetes mellitus, Alzheimers disease, dementia with behaviors, and depression.  A care plan, dated 6/7/2013, indicated the resident had a diagnosis of diabetes mellitus and was at risk for experiencing hypoglycemia (low blood sugar) and hyperglycemia (high blood	F 282		9/6/13	

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F 282	<p>Continued From page 3</p> <p>sugar). The nursing interventions included, monitor the blood sugar as ordered and notify the physician per call parameters.</p> <p>A physician's order, dated 1/10/2012, indicated the resident was to have Humalog insulin per a sliding scale (insulin given by blood sugar result) before meals and at bedtime.</p> <p>The sliding scale read as follows: Blood sugar &lt;70 call doctor 70-110 = 0 unit 111-150 = give 2 units 151-200 = give 3 units 201-250 = give 6 units 251-300 = give 9 units 301-350 = give 11 units 351-400 = give 15 units &gt;400 call doctor</p> <p>A physician order, dated 8/14/2013, indicated discontinue the Humalog insulin and to start Novolog insulin subcutaneously, four times a day using the same sliding scale.</p> <p>The August 2013 Medication Administration Record for Resident #8 included the order for Novolog insulin administration according to the sliding scale per the accu checks (blood sugar test) before meals and at bedtime.</p> <p>The Blood Glucose Monitoring Record, dated August 2013, lacked documentation to indicate the resident's blood sugar had been completed on 8/16/2013 at 4:30 p.m. and 9 p.m.</p> <p>An interview with RN #3 on 8/19/2013 at 10:41 a.m., indicated that the nurse, who worked on 08/16/13 evening shift must have forgotten to</p>	F 282			

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F 282	Continued From page 4 record the blood glucose result on the sheet. She further indicated that the blood glucose monitoring record was the only sheet that is used for recording the blood sugar and the amount of insulin the resident received.  An interview with the Director of Nursing (DoN) on 8/19/2013 at 11:20 a.m., indicated, Resident #8 blood sugar test should have been documented on the monitoring record for the date 8/16/2013, at 4:30 p.m., and 9:00 p.m. In a further interview on 8/19/2013 at 11:35 a.m., the DoN supplied the nursing 24 hour report for 8/16/13, and indicated the blood sugar results were not written on the 24 hour report sheet.	F 282			
F 315 SS=D	3.1-35(g)(1) 3.1-35(g)(2) 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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident with a urinary catheter received the necessary	F 315		9/6/13	

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F 315	<p>Continued From page 5</p> <p>treatment and services to prevent urinary tract infections, related to the placement of the urinary catheter tubing and drainage bag for 1 of 2 residents reviewed with a urinary catheter in a sample of 15. (Resident #14)</p> <p>Findings include:</p> <p>On 8/16/13 at 10:32 a.m., Resident #14 was observed in bed, the resident's indwelling urinary catheter drainage bag was observed uncovered and hanging from the side of the bed. Part of the urinary catheter drainage bag including the tubing was on the floor.</p> <p>On 8/16/13 at 2:40 p.m., the resident was observed in bed, the resident's urinary catheter drainage bag was observed hanging from the side of the bed. Part of the urinary catheter drainage bag including the tubing was observed on the floor.</p> <p>On 8/20/13 at 11:00 a.m., the resident was observed in bed, the resident's urinary catheter drainage bag was hanging on the side of the bed and part of the urinary catheter drainage bag including the tubing was observed on the floor.</p> <p>The record for Resident #14 was reviewed on 8/16/13 at 2:40 p.m. The resident's diagnoses included, but were not limited to, urinary retention, benign prostatic hyperplasia, and coccyx wounds (pressure ulcers).</p> <p>Review of the Physicain's Recapitulation Orders dated 8/2013 indicated the resident had a 16 Fr. (french) (size of catheter) indwelling urinary catheter.</p>	F 315			

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F 315	<p>Continued From page 6</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment, dated 06/28/13, indicated the resident had a urinary catheter and the resident was an extensive assist with two person physical assist for bed mobility and totally dependent with two person physical assist for transfers.</p> <p>Review of the current care plan, dated 7/1/13, indicated the resident required the use of a urinary catheter and was at risk for infections. The Nursing interventions were to position the catheter tubing and drainage bag in such a way to avoid contact with the floor.</p> <p>Review of the current Foley (urinary) Catheter Maintenance Procedure, dated 9/05 provided by the Corporate Nurse Consultant, indicated when the resident is in bed the foley catheter drainage bag should be placed in a catheter cover bag on the side of the bed and staff should ensure the bag or tubing was not touching the floor.</p> <p>Interview with the Corporate Nurse Consultant on 8/19/13 at 3:43 p.m., indicated the urinary catheter drainage bag should have a dignity bag or cover in place.</p> <p>An interview with the Corporate Nurse Consultant, at the time of the observation, 8/20/13 at 11:00 a.m., indicated the urinary catheter bag and tubing should not have been touching the floor. She indicated the urinary catheter bag had an anti- reflux valve.</p>	F 315			
F 323 SS=D	<p>3.1-41(a)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>	F 323		9/6/13	

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F 323	<p>Continued From page 7</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident was free of hazards, related to a water temperature above 120 degrees in 1 of 30 resident's hand sinks checked for water temperature. This had the potential to affect one resident who utilized the bathroom. (Resident #37)</p> <p>Findings include:</p> <p>During a resident room observation on 8/15/13 at 2:00 p.m., the water temperature in Resident #37's bathroom sink felt very hot to the touch. A thermometer check indicated a water temperature of 130.0 F (degrees). Immediately, the Maintenance Director checked the water temperature with the with facility's thermometer, which indicated a water temperature of 124.4 F. The Administrator was present and aware. The Maintenance Director and Administrator indicated a new thermometer was being used.</p> <p>In an interview with the Administrator on 8/15/13 at 2:10 p.m., she indicated the room is close to the water heater and the Maintenance Director had immediately turned down the water heater temperature.</p>	F 323			

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F 323	Continued From page 8  On 8/15/13 at 3:00 p.m. the Administrator indicated the water temperatures were checked weekly for every room and on 8/12/13 Room #30's water temperature was 115 degrees.  A facility policy, titled, "Preventative Maintenance Program", dated 04/13, and received from the Corporate Nurse Consultant as current, indicated, "...temperatures outside the parameters of 100-120 (degrees) must be reported to the Administrator immediately and corrective action initiated..."	F 323			
F 329 SS=D	3.1-45(a)(1) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		9/6/13	

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F 329	<p>Continued From page 9 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's blood sugar was monitored for insulin dosage for 1 of 5 residents reviewed for unnecessary medications. (Resident #8)</p> <p>Findings include:</p> <p>Record review was completed for Resident #8 on 8/16/2013 at 10:00 a.m. The resident's diagnoses include, but were not limited to, diabetes mellitus, Alzheimers disease, dementia with behaviors, and depression.</p> <p>A physician's order dated 1/10/2012 indicated that the resident was to have Humalog insulin per a sliding scale (insulin dosage given by blood sugar results) before meals and at bedtime.</p> <p>The sliding scale read as follows: blood sugar &lt;70 call doctor 70-110 = 0 unit 111-150 = give 2 units 151-200 = give 3 units 201-250 = give 6 units 251-300 = give 9 units 301-350 = give 11 units 351-400 = give 15 units &gt;400 call doctor</p> <p>A physician order, dated 8/14/2013, indicated to</p>	F 329		

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F 329	Continued From page 10 discontinue the Humalog insulin and to start Novolog insulin subcutaneously four times a day, using the same sliding scale.  The Medication Administration Record, dated 08/13, included the order for Novolog insulin administration according to the sliding scale per the accu checks (blood sugar test) before meals and at bedtime.  The Blood Glucose Monitoring Record, dated 08/13, lacked documentation to indicate the resident's blood sugar had been completed on 08/16/13 at 4:30 p.m. and 9 p.m.  An interview with RN #3 on 8/19/2013 at 10:41 a.m., indicated tthe nurse who worked 8/16/13 on eveing shift must have forgotten to record the blood glucose on the sheet. She further indicated that the blood glucose monitoring record was the only sheet used for recording the blood sugar and the amount of insulin the resident received.  An interview with the Director of Nursing(DoN) on 8/19/2013 at 11:20 a.m., indicated that the resident's blood sugar should have been documented on the monitoring record for the date 8/16/2013, at 4:30 p.m. and 9:00 p.m. In a further interview on 8/19/2013 at 11:35 a.m., the DoN supplied the nursing 24 hour report for 8/16/13, and indicated the blood sugar had not been documented on the 24 hour report sheet.	F 329			
F 332 SS=D	3.1-48(a)(3) 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of	F 332		9/6/13	

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F 332	<p>Continued From page 11 medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 6 residents observed during 7 medication pass observations. Five errors in medications were observed during 25 opportunities for errors in medication administration. This resulted in a medication error rate of 20%. (Residents #9, #34, and #38 )</p> <p>Findings include:</p> <p>1. During a medication pass observation on 08/15/13 at 3:32 p.m., RN #1 prepared Resident #34's medication, which consisted of ultram (pain medication) 50 mg (milligrams) and Vitamin C (used for pressure ulcer) 500 mg. RN #1 then administered the medication to the resident.</p> <p>Resident #34's record was reviewed on 08/15/13 at 4:45 p.m. The resident's diagnoses included, but were not limited to, cervical stenosis and spastic quadraparesis.</p> <p>The Physician's Recapitulation Orders, dated 08/13, indicated orders for ultram 50 mg by mouth, four times a day at 12 a.m., 6 a.m., 12 p.m. and 6 p.m. and Vitamin C 500 mg, one tablet by mouth three times a day at 8 a.m., 12 p.m., and 5 p.m.</p> <p>The Medication Administration Record (MAR), dated 8/15, indicated the ultram 50 mg was scheduled for 12 a.m., 6 a.m., 12 p.m., and 6</p>	F 332			

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F 332	<p>Continued From page 12</p> <p>p.m. and the Vitamin C 500 mg was scheduled for 8 a.m., 12 p.m., and 8 p.m.</p> <p>During an interview on 08/15/13 at 4:36 p.m., RN #1 indicated medications could be administered one hour before and one hour after the scheduled times.</p> <p>An undated facility policy, titled, "Medication Administration Policy and Procedure", received from the Corporate Nurse Consultant as current on 08/19/13 at 3:42 p.m., indicated, "...Medication will be administered within 60 minutes before and/or after the time ordered..."</p> <p>2. During a medication pass observation on 08/16/13 at 11:52 a.m., LPN #2 prepared Resident #9's medication, which consisted of Baclofen (muscle relaxant) 10 mg and Robitussin 10 ml (milliliters). Both medications were ordered to be given through the resident's feeding tube (g-tube). LPN #2 crushed the Baclofen and placed the powdered medication in a plastic medication cup. LPN #2 then poured 10 ml of the Robitussin into a plastic medication cup.</p> <p>LPN #2 then entered the resident's room and prepared to administer the medications and placed a syringe into the g-tube. LPN #2 then placed 30 ml of water into the g-tube and let the water flow in by gravity. LPN #2 then poured the powdered Baclofen into the syringe, without diluting the medication. LPN #2 then added 5 ml of water. LPN #2 then administered the 10 ml of Robitussin through the syringe without diluting the liquid medication. LPN #2 then flushed the g-tube with 30 ml of water.</p> <p>Resident #9's record was reviewed on 08/16/13</p>	F 332			

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NAME OF PROVIDER OR SUPPLIER  <b>GREEN-HILL MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 N LINCOLN AVE FOWLER, IN 47944</b>		
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F 332	<p>Continued From page 13</p> <p>at 1:30 p.m. The resident's diagnoses included, but were not limited to seizure disorder and cerebral palsy.</p> <p>The Physician Recapitulation Orders, dated 08/13, indicated orders for Baclofen 10 mg, one tablet daily via g-tube three times daily and Robitussin 10 ml via g-tube four times daily.</p> <p>A Physician's Telephone Order, dated 8/16/13 at 11:20 a.m., indicated to flush the g-tube with 30 ml of water before and after the medication pass and to flush with 5 ml of water between each medication.</p> <p>During an interview on 08/16/13 at 12:13 p.m., LPN #2 indicated she normally did not put dried medication into the syringe.</p> <p>A professional resource, titled, "Geriatric Medication Handbook", page 133, reviewed on 08/20/13 at 11:31 a.m., indicated, "...Crush immediate-release tablets into a fine powder then dissolve in 30 ml of warm water, or prescribed amount...Dilute liquid medications with 10-30 ml of warm water..."</p> <p>3. During a medication pass observation on 08/19/13 at 8:11 a.m., LPN #2 prepared Resident #38's medication, which included Seroquel (anti-psychotic) 50 mg. LPN #2 then entered the resident's room and administered the medications to the resident.</p> <p>Resident #38's record was reviewed on 08/19/13 at 8:35 a.m., the resident's diagnoses included, but were not limited to, organic psychosis and dementia.</p>	F 332			

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F 332	Continued From page 14 The Physician's Recapitulation Orders, dated 08/13, indicated an order for Seroquel 25 mg give by mouth every morning and Seroquel 50 mg tablet with 25 mg tablet (75 mg) by mouth at bedtime.  During an interview on 08/19/13 at 8:37 a.m., LPN #2 indicated she had given the wrong dose of Seroquel and she would notify the resident's Physician of the medication error.	F 332			
F 431 SS=D	3.1-25(b)(9) 3.1-48(c)(1) 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  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.  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.  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.	F 431		9/6/13	

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F 431	<p>Continued From page 15</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 dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure a medication was destroyed safely and by facility policy, related to destruction of a transdermal patch for 1 of 1 resident observed with a transdermal patch during seven medication pass observations. (Resident #38)</p> <p>Findings include:</p> <p>During a medication administration observation on 08/19/13 at 8:11 a.m., LPN #2 prepared Resident #38's medication, which included an Exelon patch (dementia medication) 9.5 milligrams (mg) over 24 hours.</p> <p>LPN #2 applied gloves, and placed the Exelon patch on the resident's left upper back. LPN #2 then removed the prior days patch, removed her gloves with the old patch inside the glove and placed the gloves in the resident's waste basket in the resident's bathroom. LPN #2 then washed her hands, exited the room and walked to the Nurses' Station.</p>	F 431			

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F 431	Continued From page 16 During an interview on 8/19/13 at 8:25 a.m., LPN #2 indicated the old Exelon patch was placed in the glove she took off in the resident's room and was placed in the waste basket in the resident's bathroom. She indicated the facility policy was to place the old patch in the Sharps' container. LPN #2 indicated there could be medication left on the patch in the waste basket.  Facility policy, dated 9/05, titled, "Transdermal Patch Administration", received from the Corporate Nurse Consultant as current, indicated, "...Locate and remove existing patch if applicable and discard into the sharps container. If it does not contain a controlled substance, you may discard in the medication cart trash...."	F 431			
F 465 SS=E	3.1-25(o) 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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred walls and doors, gouged walls, splintered doors, uncovered call light wires, and rusted vents on 4 of 4 halls throughout the facility. (North, West, South, and East Halls). This had the potential to affect 12 residents residing in the facility.	F 465		9/6/13	

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F 465	Continued From page 17 Findings include:  During the Environmental tour on 8/20/13 at 1:00 p.m., with the Administrator and the Maintenance Director, the following was observed:  1. North Hall  a. There bathroom walls were marred in Room 25-A. The bottom of the bathroom door was marred and the bathroom vent was rusted. One resident resided in this room.  2. West Hall  a. The wall outside the bathroom was marred and the wall under the window in Room 11-A was marred. There were gouges on the wall behind the bed. The door to the room was splintered on the sides. The wires were exposed where the call light cord plugs into the wall. Two residents resided in this room.  b. The baseboard in the bathroom in Room 31-B was tacked to the wall using thumb tacks. The bathroom door was marred. One resident resided in this room.  3. South Hall  a. The floor vent near the wall was rusted in Room 16-A. There were gouges on the bathroom wall. One resident resided in this room.  b. The baseboard was loose in the bathroom of Room 21-A. Two residents resided in this room.  c. There was a gouge out of the trim on the left	F 465			

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F 465	<p>Continued From page 18</p> <p>side of the bathroom door frame in Room 21-B. The inside of the bedroom door was marred. Two residents resided in this room.</p> <p>d. The bathroom door was marred in Room 22-B. One resident resided in this room.</p> <p>4. East Hall</p> <p>a. The bathroom door in Room 39-A was marred. Two residents resided in this room.</p> <p>b. There was a large gouge in the wall next to the bed in Room 42-B. Two residents resided in this room.</p> <p>Interview with the Maintenance Director and the Administrator at the time of the tour, indicated all of the areas were in need of repair.</p> <p>3.1-19(f)</p>	F 465			