

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2012
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NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC	STREET ADDRESS, CITY, STATE, ZIP CODE 510 W MEDCALF DALE, IN 47523
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: June 4, 5, 6, 7, 8, 2012</p> <p>Facility Number: 000170 Provider Number: 155270 AIM Number: 100287490</p> <p>Survey Team: Martha Saull, RN TL Carole McDaniel, RN Terri Walters, RN Dorothy Watts, RN</p> <p>Census By Bed Type: SNF/NF: 48 Total: 48</p> <p>Census By Payor Type: Medicare: 5 Medicaid: 39 Other: 4 Total: 48</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/14/12 Cathy Emswiller RN</p>	F0000		
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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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F0156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to provide proper liability notice and beneficiary appeal rights on approved forms with acknowledgement of receipt to 3 of 3 residents who met the criteria for whom Medicare services were denied. Resident# 17, Resident# 21, Resident # 31</p> <p>Findings include:</p> <p>On 6/07/12 at 2:30 P.M. the Administrator was interviewed and provided copies of forms which the Secretary Treasurer of the facility corporation was said to have provided residents or their representatives to inform them of probable denial of payment by Medicare for therapy services and appeal rights. During</p>	F0156	<p>1. It is the policy of this facility to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice of the State developed under the Act. Such notification must be made prior or upon admission and during the residents stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the</p>	07/08/2012	

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	<p>interview at that time, the Administrator indicated the Secretary Treasurer provided the information to residents and their representatives form her office base in Florida by telephone.</p> <p>The forms provided were for: Resident 21 with therapy services being terminated on 2/18/12. Resident 17 with therapy services being terminated on 9/20/11 Resident 31 with therapy services being terminated on 6/18/11</p> <p>Documentation was lacking to establish residents or representatives were informed in writing or understood their appeal rights.</p> <p>Each form had the choice not to submit a demand bill checked and the resident or representative acknowledgement of notice signature signed by the Secretary Treasurer rather than a genuine signature.</p> <p>The forms were not approved in content or format, by HCFA, for notification use by facilities.</p> <p>On 6/08/12 at 1:30 PM the Secretary Treasurer was interviewed by phone. She indicated she was using forms she had used for a number of years</p>		<p>resident may not be charged; these other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i) A and B of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924c which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and</p>		

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	and really didn't realize there were approved forms required or that information needed to be provided in writing with a means to verify receipt. 3.1-4(a)		telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsmen program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirement. The facility must inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and at the individual's option, formulate an advanced directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.2. Affected residents		

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			include Residents #17, 21 and 31. 3. A new approved form has been established to ensure the residents or representatives are informed in writing and understand their appeal rights. The forms will be sent to representatives as needed with a certified certificate the letter was mailed as proof in case the stated document is not returned. Residents who are able to sign the form with be given the form at the facility and the MDS Coordinator will review the document with the resident and have them sign the document. 4. The MDS Coordinator will audit the forms monthly continuously to ensure they have been completed. Addendum: The practice has been deficient for all the residents. A new form has been created and The Financial Manager and MDS Coordinator have been educated regarding the form and the use of the form. They will have the form signed or send it out as delegated above. The residents and legal representatives will be educated as the patients use Medicare benefits.		

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F0159 SS=E	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount</p>				

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	<p>in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to provide weekend access to resident funds for 5 of 6 residents who met the criteria and kept funds on account with the facility. This had potential to affect 28 residents with monies in their accounts. Resident #17, Resident# 21, Resident # 41, Resident# 36, Resident# 28</p> <p>Findings include:</p> <p>During resident interviews on 6/04 and 6/05/12 5 residents indicated they could not get funds from the office on the week. They were Residents 17, Resident 21, Resident 41, Resident #36 and Resident 28.</p> <p>On review of facility fund accounts on 6/8/12 at 1:30 P.M. the residents had balances in their accounts which could potentially be withdrawn.</p> <p>On 6/08/12 at 2:05 PM the Administrator was interviewed</p>	F0159	<p>1. It is the policy of this facility to hold, safeguard, manage, and account for the personal funds of residents upon written authorization if they are deposited within the facility. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account that is separate from any of the facility's operating accounts. All the interest earned on resident's funds must be pooled on each resident's share. The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest bearing account or petty cash fund. The facility must maintain separate accounting for each resident. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than the resident. The individual financial record must be available through quarterly statements and on request to the resident or his/her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than</p>	07/08/2012

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	<p>regarding access to funds on the weekend. She indicated residents were asked to estimate their weekend needs and access adequate funds to cover the weekend on Friday. There was no system in place to ensure unforeseen weekend withdrawals could be made.</p> <p>3.1-6(b)</p>		<p>the SSI resource limit for one person. 2. Affected residents include #17, 21, 41,36 and 28. This could affect 28 residents with monies in their account.3. A new policy was established to include weekend disbursement of money to residents. Petty cash will be left in an envelope on each Nurses Station in the Med Cart with \$50 and a sign out sheet for the Nurse and Resident to sign should they need funds on the weekend. A new sheet will be posted weekly with an updated funds amount to ensure they have funds available before disbursement given. The funds will be replenished weekly.4. The Administrator will ensure compliance by checking the monies weekly and replacing the given money to residents. This will be an on going log.Addendum: I corrected the practice by placing petty cash at each nurses station and educating all residents they would have funds readily available as long as they had funds available in their account. All the other residents were reveiwed and those with funds available could potentially be affected. Staff and residents were educated regarding the funds and the staff on the procedure for documenting the funds.</p>		

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F0241 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> <p>Based on observation and interview, the facility failed to ensure the dignity of 1 of 2 residents who met the criteria for dignity in regards to a protruding, exposed abdomen with a urostomy and colostomy visible. Resident #1</p> <p>Findings include:</p> <p>The MDS (minimum data set assessment) dated 4/17/12 indicated the following for the resident: total cognition score of 15, which indicated independent cognition; required extensive assistance with dressing; total dependence required for toilet use and personal hygiene required extensive assistance.</p> <p>On 6/5/12 at 1:15 P.M., Resident # 1 was observed seated in his wheelchair, in the foyer of the entrance to the facility. He was wearing a t-shirt that was very tight and raised above his waist line exposing his colostomy bag (collects bowel content) and urostomy bag (</p>	F0241	<p>1. It is the policy of this facility to promote care of residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality.2. Affected Resident #1 was interviewed 6/19/12 and reviewed that his basic right is to have the right to be treated with dignity in recognition of your individuality and preferences. Resident was questioned about how he felt about his colostomy bad and the bag being exposed. Residents clothing reviewed to see if it was an issue. Resident reports that this is his home and he is comfortable and has no issues or concerns with his right of dignity. Resident educated regarding other residents right of dignity and respect. Resident verbalized understanding of how other residents may not want to see the colostomy bag exposed. Resident agreed to be more aware of other residents preferences and will cover the bag by pulling his shorts higher or wearing longer shirts. 3. Completed resident preference plan of care and will start monitoring compliance with</p>	07/08/2012			

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	<p>collects urine). Visitors entered and exited the facility through this main entrance.</p> <p>6/5/2012 at 2:12 P.M., Resident #1 was observed in his wheelchair exiting the dining room/activities room. He self propelled himself to the entrance hall where he stopped and sat for 25 minutes. His shirt was very tight and was raised, his colostomy and urostomy bags were resting upon his protruding abdomen. A light yellow substance was noted in one bag and a gray substance was noted in the other. Visitors and family members were observed in the same area.</p> <p>On 6/6/2012 at 12:30 P.M. Resident #1 was observed in his wheelchair self propelling himself down East hall towards the nurses station where he stopped to talk to LPN # 2 at the medication cart. At this time he had his shirt pulled above his waist line exposing his urostomy and colostomy bags .The staff passed him in East hall while engaged in their daily tasks. No staff member stopped at this point to direct Resident #1 to pull his shirt down over his abdomen.</p> <p>During an interview with the Social Services Director on 6/8/2012 at 1:12 P.M., she indicated she had not</p>		<p>keeping bag covered. Longer shirts have been purchased for his wear if he chooses.4. Social Services will monitor resident for compliance by performing spot checks 2x/weekly for 2 months and then 1x/weekly for 2 months. Social Services will review tracking monthly. Social Services will inservice the staff on Dignity.Addendum: Will monitor monthly for compliance.</p>		

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	<p>noticed Resident #1 sitting in his wheelchair with his shirt pulled up. She stated, "nobody wants to see that."</p> <p>3.1-3(t)</p>				

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F0253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, record review and interview, the facility failed to provide adequate housekeeping and/or maintenance service for 20 of 40 residents, equipment for 2 of 2 units and/or carpeting and resident lounge areas.</p> <p>Residents 17, 22, 30, 27, 33, 35, 11, 43, 38, 16, 14, 18, 25, 45, 23, 36, 31, 39, 7, and 40 on the East unit and West unit</p> <p>Findings include:</p> <p>The environmental tour of the facility was completed on 6/08/12 from 9:50 A.M. to 10:45 A.M.</p> <p>Fourteen of 20 residents had all or a combination of the following problems noted in their bathrooms (Residents 17, 30, 27, 33, 35, 11, 38, 14, 18, 25, 23, 36, 31, 40 as follows:.</p> <p>Bathroom toilet bowls were heavily stained deep yellow/brown in the base of bowls.</p> <p>Jagged or cracked caulk around toilet bases, harboring dark gray black and/or yellow orange matter and at</p>	F0253	<p>1. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.2. Affected Residents include Residents #17,22,30,27,33,35,11,43,38,16,14,18,25,45,23,36,31,39,7 and #40.3. The bathroom toilets will be deep cleaned and replaced if the stains are not removed from the toilet bowls. The caulk will be redone on all toilets mentioned. Floors will be buffed, waxed and replaced as necessary. The black seepage from the tiles will be removed from the floors. The bathroom fixtures will be scrubbed and replaced if unable to be free of mineral deposits and metal corrosion.The closet doors will be affixed to the floor for Residents #27,33,35,39 and 7.The window blinds will be replaced for Residents #27,33 and 35.All bedroom floors will be scrubbed to remove dirt and debris on floors and in edges of floor.All paint in resident rooms will be touched up or repainted to assure they are the same color over their entirety.The weight scale will be cleaned.The walls and doors of the facility will be scrubbed and repainted to remove hand soil and scuffs.The</p>	07/08/2012	

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	<p>times accompanied with urine odor. Discolored floor staining and or worn floor surface finish exposing areas without surface floor pattern. Floors soiled with accumulated dirt, dust and debris in corners and edges of flooring. White vinyl floor tile seams with residual dried black glue seepage. Toilet seat finishes marred, scarred or rough. Bathroom fixture finishes with accumulated mineral deposits and/or metal corrosion.</p> <p>Five of 20 residents had sliding closet doors which were not affixed to the floor. The intended guide bracket for the closet doors (on the floor) swung back and forth when touched. They were Resident 27, 33, 35, 39, and 7.</p> <p>Residents 27,33 and 35 had window blind slats twisted and bent. The vinyl veneer of the window face was torn, exposing dried black glue.</p> <p>The bedroom floors of all 20 residents were soiled with accumulation of dark gray dirt and debris in corners and edges of the floor.</p> <p>There were paint chips and/or wall damage and/or areas of missing paint with prior room colors showing</p>		<p>carpet will be removed from the hallway and tile will replace the carpet. Deep cleans will be done as scheduled whether they are short of staff or not, the staff will flex their hours to complete these tasks. 4. Maintenance will perform weekly checks x2 months and then monthly checks of the facility and have a list of items that need to be replaced or cleaned to ensure proper quality of rooms and the facility. Housekeeping Supervisor will complete weekly checks x4 weeks of deep clean schedule to ensure rooms are being properly cleaned and then 2x monthly to ensure compliance. The weight scale will be added to a monthly cleaning schedule by the Administrator. Addendum: Monthly audits will be completed to ensure compliance.</p>				

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	<p>through in rooms off all 20 residents. Residents 45, 36, 11, and 23 had horizontal wall guards removed with mounting brackets in place and exposed prior room paints.</p> <p>The East unit weight scale had a scale platform which allowed both standing and seated weights to be measured. There was a handle bar across the top for standing weights. It was covered with a white vinyl padding which was heavily soiled gray with tacky accumulated hand soil. The front of the base frame had white surface finish which was worn to exposing metal with heavy soil and wear, rendering it dark gray. The floor of the weight platform was laden with loose debris including food matter, hair and dust in its corners.</p> <p>The thresholds to resident rooms had accumulated floor soil and the painted white doors of resident rooms and utility rooms in resident halls on both units had accumulated gray hand soil around hardware and/or scuffs.</p> <p>The facility entryway was carpeted in the center of the facility, extending down to double doors on each hall. The carpet was chestnut colored with a pattern. It was heavily soiled dark gray in areas, obscuring the pattern.</p>				

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	<p>It had a variety of stains from 4 inch areas to 10 inch areas scattered on it's surface. There were threads unraveled in a loose fringe horizontally across the halls where carpet pieces had been joined.</p> <p>On 6/08/12 at 12:17 P.M. the Housekeeping Supervisor was interviewed. She provided deep clean schedules for resident rooms. On review of the last 20 weekdays there were 6 resident rooms scheduled which were not completed and on the West unit there 4 rooms not completed. The Housekeeping Supervisor attributed the missed assignments to having lost one employee a week before and had just taken over her position. She indicated the toilets were generally cleaned with an all purpose "Pink cleaner" but if heavily stained brown they had been treated with chlorine bleach in the bowls to soak. That process was ineffective on a number of toilets that were too far gone. She indicated the carpet was cleaned professionally from an outside service which was called whenever it needed to be but as far as she knew, they were not due to come.</p> <p>3.1-19(f)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident with pain was monitored for pain resolution for 1 of 4 residents who met the criteria for pain in a sample of 12. Resident #22</p> <p>Findings include:</p> <p>The clinical record of Resident #22 was reviewed on 6/5/12 at 11 A.M. Diagnoses included, but were not limited to, the following: Mellitus, chronic lower extremity cellulitis, chronic pain, arthritis and low back pain. An MDS (minimum data set assessment) dated 2/22/12, indicated the following: on scheduled pain medication, received non medicinal interventions for pain, no prn pain medicine given, pain was present frequently and an intensity of 5 and day to day activities have been limited due to the pain.</p> <p>A plan of care updated on 3/20/12 and</p>	F0309	<p>1. It is the policy of this facility to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.2. Resident Affected #223. Resident's #22 pain regime and medications were again reviewed with his attending physician. Resident was examined by MD and Lortab was increased to 7.5/500 one tablet tid. Neurotin 1200mg tid, capsaicin cream prn and tramadol/apap 37.5/325 two tablets every four hours prn all remain the same as previously ordered. A mandatory inservice will be done for licensed staff and QMA's regarding the Pain Assessment Sheet and our policy on Medication Pass Guidelines as it relates to documentation of time, dose, route, medication and its effectiveness on the back side of the Medication Administration Record. Based on the pain medication effectiveness, residents will be offered their PRN analgesics along with</p>	07/08/2012			

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	<p>6/20/12 addressed the following problem: "pain management." Interventions included, but were not limited to, the following: "Monitor and record effectiveness..."</p> <p>A care plan review summary, dated 4/17/12 indicated the following for pain: has mild pain which occurs daily.</p> <p>Nurses notes, dated 5/11/12 at 5 A.M. indicated the following: "...alert and oriented x 3 (person, place and time)...dependent with care...c/o (complained of) discomfort being achy all over. Receives routine pain med (medication) in A.M..."</p> <p>The May 2012 MAR (medication administration record) was reviewed on 6/6/12 at 11 A.M. This form indicated the resident was not medicated on 5/11/12 with prn pain medication. This form also indicated the resident was medicated on 5/20/12 and 5/27/12 with prn pain medication Tramadol. The reverse side of this form, lacked documentation of the effectiveness of the medication. This form indicated the Tramadol had an order date of 5/15/09 and was to be given "2 tabs (tabs) by mouth every 4 hrs (hours) as needed for pain." This MAR also indicated the resident received Lortab 5/500 (pain medicine) 3 times a day at 6</p>		<p>non-pharmaceutical pain relieving measures. 4. Residents will continue to be assessed, using the Pain Assessment tool on Admission, Quarterly, Change of Condition/New Medication and PRN for pain management effectiveness.A Pain Medication Administration Record Audit will be done for pain medication effectiveness, residents response and use of PRN medications, daily x 4 weeks, monthly thereafter x 6 months.Addendum: A pain assessment will be completed on every resident in the facility.</p>				

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	<p>A.M., 4 P.M. and 8 P.M.</p> <p>A quarterly nursing assessment, dated 5/18/12 indicated the following for the resident: "yes" the resident had pain now and "yes" the resident had pain recently.</p> <p>A pain assessment and data collection form dated 5/18/12 indicated the following: "rate the pain intensity since last review at its worse: 6 (by the scale on the form, 6 would be defined as moderate pain); "has the resident had any increase in pain complaints or symptoms since the last review? yes, but continues on lortab routinely..."</p> <p>On 6/5/12 at 8:40 A.M., the resident was interviewed and indicated he has pain in his left leg. He indicated this is due to arthritis and nerve damage that won't go away. He indicated it keeps him awake and that staff give him pain medicine but it (the medication) doesn't get rid of it (the pain). Resident #22 stated he's had this pain for years and indicated he's told nurses it keeps him awake at night. The resident indicated it is his "toes on my left, sometimes it goes all the way up my leg."</p> <p>3.1-37(a)</p>						

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to provide monitoring during meal time for 6 of 6 observed residents on the west unit dining area who met the criteria for supervised dining for 1 of 2 dining room meal observations. Residents #4, #6, #13, #30, #44, and #8</p> <p>Findings include:</p> <p>1. On 6/4/12 at 12:30 P.M., on the west unit (200 hall) dining area, 6 residents were observed to be feeding themselves their noon meal. CNA #6 had passed out their trays, provided set up and was assisting with feeding at times. CNA # 6 at this time, then assisted Resident # 12, to her room across from the dining area on the 200/west hall. CNA #6 indicated to Resident # 12, she would help her brush her teeth. CNA#6 then shut Resident #12's room door. No staff were available on the 200/west unit dining area for continued monitoring of the noon</p>	F0323	<p>1. It is the policy of this facility to ensure the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.2. Resident # 4,6,13,30,44 and 8 are affected.3. The clinical team met on 6/9/12 and discussed our dining service as it relates to safety. Each resident requiring supervision during meals on all three areas of dining, were placed in a specific table seating arrangement that better facilitates safety and supervision. Supervision of Par Levels were determined and placed at each nursing station. A clipboard was designated, one on each of the three dining areas, to review specific dietary and feeding techniques, recommended by our Speech Therapist, that can be referenced at a glance by our staff. Updates to each resident's recommendations will be done, as needed, by our Speech Therapist, with accompanied Inservice Training Sheet on her new recommendations. Mandatory</p>	07/08/2012			

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	<p>meal.</p> <p>On 6/4/12 at 12:32 P.M., the Administrator was observed off the 200 unit walking toward the main dining room. The Administrator was made aware at this time that the residents in the 200/west dining area were unsupervised . The administrator indicated at this time the residents in this dining area should not be left unsupervised.</p> <p>On 6/4/12 at 12:55 P.M., CNA #6 continued to assist residents with lunch in the west 200 dining area. She assisted feeding Resident #4 at intervals. On 6/4/12 at 12:55 P.M., the Director of Nursing (DON) was interviewed at this time regarding residents eating in the west/200 dining area. She indicated at this time these residents should have staff present during the meal for monitoring.</p> <p>On 6/4/12 at 1:50 P.M., a list from the DON was reviewed which indicated 4 of the 6 residents observed eating in the west/200 dining area unsupervised had swallowing precautions (Residents # 4, #44, #8, and #30).</p> <p>On 6/4/12 at 2:30 P.M., Resident #4,</p>		<p>Inservicing will be done to all nursing staff that are required to feed residents. These services include: NURSING DEPARTMENT: Resident Dining Services, Speech Therapy Clipboard, Dining Room Feeding Assistance chart and General Following and Feeding Precautions.4. A Dining Service Audit will be conducted for the purpose of accuracy of table position, supervision, speech technique use and effectiveness. This audit will be done daily x 4 weeks, weekly x 4 weeks and monthly thereafter x 6 months. Any staff not complying with facility procedures will be disciplined according to policy.</p>				

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	<p>#44, #8, #30, and #6's current care plans were reviewed. Resident # 4's care plan (4/10/12) included but was not limited to: a history of swallowing difficulties and to monitor for signs and symptoms of aspiration. Resident #6's current care plan (3/22/12) included but was not limited to: monitor for signs and symptoms of aspiration and history of swallowing difficulties. Resident #30's current care plan (4/26/12) included but was not limited to: monitor for signs and symptoms of aspiration and history of dysphagia (Inability or difficulty in swallowing). Resident #8's current care plan (5/11/12) included but was not limited to: history of dysphagia. Resident #44's current care plan (2/28/12) included but was not limited to: history of swallowing difficulties.</p> <p>On 6/6/12 at 2:30 P.M., the DON was interviewed regarding lack of monitoring/supervision for residents on west/200 dining area on 6//4/12 noon meal. The DON indicated this was a "valid" concern regarding these residents observed unmonitored. She indicated Resident #4 was on a thickened liquid diet and needed monitoring . She also indicated Resident #44's diet order- included to cut meat in small bites. The DON</p>						

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	<p>indicated at times Resident #44 will put too much food in his mouth if not monitored. She also indicated Resident #8 had a recommendation for a mech soft diet and that the resident had refused this diet . She indicated the FSM (Food Service Manager) had gotten the resident to agree to take the skin off polish sausage. The DON indicated that Resident #6 eats very slowly and she and all the residents in this dining area should be monitored. The DON indicated at this time it was a standard facility protocol (including the main dining room) for independent residents also to be monitored when eating at meal times. The DON indicated at this time she was not sure if there was a facility policy for monitoring of residents in the 200 unit dining room. The DON indicated staff will also be inserviced in regard to monitoring at meal times.</p> <p>On 6/7/12 at 2:22 P.M., a copy of Resident #6's current June 2012 physician's orders was reviewed. These orders included a diet order of : "... Mechanical soft diet with thin liq (liquids), eat at feeder table & monitor-divided plate for meals..."</p> <p>On 6/8/12 at 8:47 A.M., a copy of</p>						

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	<p>Resident #4's current June 2012 physician's orders was reviewed. These orders included a diet order of : "... Pureed w(with)/ honey thick liq (liquids) -double entree all meals, donut in milk or coffee ok w/ 1:1 supervision..."</p> <p>On 6/7/12 at 2:08 P.M., received and reviewed facility policy entitled: "Nursing Department: Resident dining Services. (Dated/6/2012)" This policy included but was not limited to: "...Dining areas on East and West will be attended at all times by nursing or a certified dining person. At no time will the residents in any dining room be left unattended while eating. Personnel area to be with each dining room resident until their food, and fluids are completely consumed..."</p> <p>On 6/8/12 at 7:30 A.M., during interviewed with the DON, she indicated the policy entitled "Nursing Department: Resident Dining Services" was a draft. She indicated she still needed to get with the Speech Therapist and work on the policy and then inservice the staff.</p> <p>3.1-45(a)(2)</p>			

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication rate of less than 5 percent. Eleven residents were observed for medication administration. Four errors in medication administration were observed during 62 opportunities. This resulted in a medication error rate of 6.45%. Resident # 29, Resident #1, Resident # 26</p> <p>Findings include:</p> <p>1. On 6/7/12 at 11:10 A.M., RN#20 was observed administering medications to Resident #29. At this time, RN #20 had picked up the nebulizer device which was sitting at the resident's bedside. RN #1 indicated the medication reservoir had liquid left in it. RN #20 stated "it must have been left over." She took the nebulizer reservoir into the bathroom and rinsed it out. She then put the liquid nebulizer medications (Albuterol 0.083% and Atrovent 0.02%) in the reservoir, put the treatment mask on the resident and began the treatment. RN #20 was not observed to assess the resident's lungs prior to the nebulizer treatment. RN #20 left in the resident in her wheelchair with the nebulizer mask on and stated "I'll be back to check on you." RN #20 then left the room.</p>	F0332	<p>1. It is the policy of this facility to ensure it is free of medication error rates of five percent or greater.2. Resident Affected #29,1 and 26.3. Licensed staff will be inserviced on Medication Pass Guidelines, Nebulizer Treatments with post test and Spacing and Proper Sequence of Inhaled Medications. A list of medications that should be shaken well before using was placed inside each Medication Administration Record binder for easy and quick access for licensed staff. New Nursing Drug Handbooks 2013 were ordered for each wing.4. A Medicaiton Pass Audit will be done for the purpose of accuracy daily x 4 weeks , weekly x 4 weeks, monthly thereafter for 6 months. Any licensed staff not complying with medication pass standards will be disciplined according to policy.Addendum: The surveyor corrected the nurse and the medication was administered correctly. Had the potential to affect all residents whom receive this medication. This nurse and all nurses inserviced on proper medication pass.</p>	07/08/2012			

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	<p>At 11:20 A.M., the resident was observed in her room. She was in her wc (wheelchair) and had taken off the nebulizer treatment mask and hung it on the bedside table. The machine was observed still running and the medicated vapor continued to be dispersed from the mask. The resident was observed in the bathroom in her bedroom. At 11:21 A.M., the nurse was in the hall. The resident remained in the bathroom, still with the nebulizer treatment on. At 11:24 A.M., the resident was still in the bathroom. The medicated vapor was still observed being dispersed to air. At 11:28 A.M., the resident was observed back in her wc with the nebulizer treatment in place on her face. At 11:30 A.M., RN #20 went back into the room and stated "It's been about 10 minutes." RN #20 removed the nebulizer mask from the resident's face with the medicated vapor continuing to be dispersed. Clear liquid was observed in the nebulizer reservoir. At this time, RN #20 was interviewed. She indicated she was unsure how much fluid was left in the nebulizer reservoir. A medication administration cup was obtained and the remaining contents of the nebulizer reservoir were measured. RN #20 read the amount of clear fluid to be 1/2 teaspoon. There was no method to determine what specific amount of each of these medications had not been administered. RN #20 indicated "this was just left over fluid." RN #20 left the room without reassessing the resident's lungs after the treatment was discontinued.</p> <p>At 11:37 A.M. RN #20 was interviewed. She indicated she was not aware the resident had gone to the bathroom and taken the nebulizer treatment off.</p>			

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	<p>On 6/7/12 at 2:50 P.M., the DON (Director of Nursing) provided a current but undated copy of the policy and procedure for "Procedure for Administering Medication via Volume Nebulizer." This policy included but was not limited to, the following: "Assess the resident: Listen to breath sounds bilaterally...Re-assess the resident. Listen to breath sounds bilaterally. Compare current breath sounds to pre-treatment...Continue treatment until all medication is gone. On average, nebulization will take 15 - 20 minutes..."</p> <p>On 6/8/12 at 8:41 A.M., the DON (Director of Nursing) provided a current copy of the resident's "Respiratory Flow Sheet." This form included, but was not limited to, the following: "Pulse Pre; Pulse Post; lung sounds." For the date of 6/7/12, a "D" was documented for "lung sounds." Documentation was lacking of status of the lung sounds before and/or after the treatment was administered.</p> <p>At this time, the DON also provided a copy of the resident's current medication administration record (MAR) for June 2012. This MAR indicated the following: 6/29/10: Albuterol 0.083% solution per nebulizer twice daily; Atrovent 0.02% solution twice a day.</p> <p>2. On 6/7/12 at 9:20 A.M., RN #20 was observed passing medications to Resident #1. RN #20 handed the resident his combivent inhaler. Immediately after the resident received his combivent inhaler, RN #20 gave the resident his flovent inhaler.</p>			

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	<p>On 6/7/12 at 3 P.M., the DON provided a copy of the facility medication pass guidelines. The guidelines indicated the following: "Multiple puffs separated by at least 1 minute."</p> <p>On 6/8/12 at 8:42 A.M., the DON was interviewed. She indicated she had spoken with the facility pharmacy and was directed to wait 5 - 15 minutes between administration of multiple inhaler type medications.</p> <p>3. On 6/05/12 at 7:55 A.M. Resident # 26 was observed receiving medications from RN #4. The nurse prepared Tegretol suspension (100mg in 5 milliliters) one teaspoon. The bottle from which the nurse poured the medication was RX # 26172220. It was marked in bold on the bottle with 2 separate stickers, one blue and one yellow and red which directed "SHAKE WELL BEFORE USING." The nurse failed to shake the contents but poured the dose directly. When the nurse was prepared to administer the dose to the resident she was informed of the error and correctly prepared the dose stating she was not aware Tegretol had to be shaken.</p> <p>The medical record of Resident 26 was reviewed on 6/05/12 at 1:00 P.M. There was an order from 5/14/12 for Tegretol Liquid 1 teaspoon by mouth twice daily.</p> <p>3.1-48(c)(1)</p>						

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure security of the medication room from unauthorized access on 1 of 2 units.</p>	F0431	1. It is the policy of this facility to employ a pharmacist who records medications and disposal of all controlled drugs in detail and has an accurate reconciliation. The	07/08/2012			

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	<p>This had the potential to impact 25 residents residing on the East unit. Resident #49</p> <p>Findings include:</p> <p>On 6/07/12 at 8:40 A.M. the locked East unit, inside the nurses' station, medication room door was open approximately 3 inches. The locked gate to the nurses station was unlocked. There was one staff on the unit, CNA # 8. LPN #6, assigned to the shift was not on the unit. There was no staff supervising the nurses' station until the nurse returned at 8:48 A.M. In the nurses absence, CNA # 8 entered the nurses station twice going into the pantry to get supplies and leaving the gate and medication room door open. The medication room was observed to contain a variety of refrigerated medications, suppositories, vaccines. There were a variety of syringes in supply boxes.</p> <p>On 6/07 at 1:00 P.M., the Administrator was interviewed regarding facility security policies. She indicated the staff know only licensed people should have access to the drug room and the observation reported to her was unacceptable practice.</p>		<p>pharmacist also determines the drug records are in order and controlled drugs are maintained and periodically reconciled. Drugs and biologicals in this facility will be labeled and include the appropriate accessory and cautionary instructions and the expiration date when applicable. The drugs and biologicals must be stored in locked compartments under proper temperature controls and only licensed personnel shall have access to the keys. This facility will provide seperately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II 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.2. Affected #49 with the potential to impact 19 residents that reside on East Unit.3. All licensed staff will be inserviced on Medication/Drug Security.4. A Medication Door/Drug Security Audit will be done daily x 4 weeks, weekly x 4 weeks and monthly thereafter x 6 months. Any licensed staff not complying with facility procedures will be disciplined according to policy. Addendum: The gate to the nurses station will be locked to deter residents from entering. The Med Door will be locked at all times when the nurse is not in the Med Room, Only the Nurse on</p>				

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	<p>On 6/8/12 at 11 A.M., the East unit (locked dementia unit) medication room was toured. At this time, Resident #49 was observed sitting at the table in the dining room. LPN #2 was observed in the medication room with the door open. At 11:04 A.M., Resident #41 was observed sitting in a chair behind the nurses station. The waist high, swinging, gate type door to the nurses station was unlocked at this time. CNA #5 came from the dining room and ushered the resident out from behind the nurses station and locked the swinging gait door.</p> <p>3.1-25(j) 3.1-25(k) 3.1-24(l)</p>		<p>the Unit will have the key to the Med Room, and the Audit will be a check off sheet to ensure the door is locked when Management does the unannounced audit.</p>		

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F0465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation record review and interview, the facility failed to provide clean resident lounges, nurses stations, pantries, carpets and medication rooms and carts on 2 of 2 units.</p> <p>Findings include:</p> <p>The environmental tour of the facility was completed on 6/08/12 from 9:50 A.M. to 10:45 A.M.</p> <p>1. The resident lounges on both the East and West unit had resident/public lounges delineated by a white porch fencing as a room divider. The lower horizontal rungs and base of each support post had accumulated charcoal colored soil, as did the floor onto which the posts were mounted. There was dust, debris around the each post.</p> <p>East and West nurses stations provided one wall of each of the lounges. The white beadboard paneling around the East and West nurses station was soiled, spattered</p>	F0465	<p>1. It is the policy of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.2. Affected Residents include all residents of the facility.3. The fencing on each unit will be cleaned, the Nurses Stations, med rooms, and clean utility rooms will be cleaned and sanitized and the microwave will be cleaned. The refrigerators will be cleaned and dethawed. The Medication and Treatment carts on both units will be cleaned, the velcro will be removed from the East Wing gate at the Nurses Station, the nurses station floors will be buffed, waxed or replaced if necessary. The chairs will tears will be thrown away and replaced if necessary. The clean utility floor will be buffed, waxed and replaced if necessary. Clean utility walls will be scrubbed. 4. The Housekeeping Supervisor will monitor weekly x4 weeks and then monthly to ensure these areas are kept clean.Addendum: Monthly Audit to ensure compliance. The fencing has been repainted, the torn chairs thrown away, the nurses station scrubbed, the pantrys scrubbed. The other issues will be</p>	07/08/2012	

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	<p>and had accumulated charcoal colored dirt and dry debris along the floor moldings. Atop the high counter on each station there was a fan with both front and back gratings laden with layers of brown /gray dust as was the motor housing and blades. On the East unit, the fan periodically spit dust clots out on the counter.</p> <p>Four of 4 medication and treatment carts on both the East and West units had drawer handles with accumulated soil and/or tape glue build up with adhering soil, and/or splatters under and around name plate holders and push handles.</p> <p>2. The East unit had a wooden locking gate to prevent unauthorized entry. Outside the gate on both sides, where the gate was affixed to the wall and nurses station, there were 4 strips of Velcro. Each strip had caught accumulated hair, threads and matter. CNA # 8 indicated the Velcro had been part of a fabric gate which had been unsuccessfully tried before the wooden gate which had been in place for "quite awhile."</p> <p>The East Nurses station floor was heavily soiled with loose dirt and debris including food particles, paper</p>		completed in the next two weeks.		

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	<p>clips, dust balls and soil. There was an accumulation of charcoal colored soil around edges of the station floor and beneath the desk. Inside the nurses station there were doors into the medication room and the unit pantry.</p> <p>The Medication room sink had dried spills in the bottom and debris obstructing the drain. It had dried soil lines on the bowl and accumulated dried gray/brown scum dust and hairs. The counter and surfaces of stored tackle boxes, oxygen tank, pharmacy caddy and refrigerator were all laden with dust which obscured the surface color of the items and had a network of undisturbed cob webs and dead bugs. The floor was heavily soiled with dust dirt and debris accumulated. There were 2 drawer faces partially broken away from the drawers. During tour, LPN #6 had difficulty opening the medication room door when one of the drawer faces fell forward obstructing free door swing into the med room. CNA # 9 assisted the nurse to pry the door past the obstruction.</p> <p>The chair desk upholstery was stained and heavily soiled while chair legs had accumulated dust and dirt.</p>				

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	<p>The Pantry area floor and counter were soiled with dried spills and food matter. The microwave interior had accumulated tacky soil and spatters inside the cabinet and on the ceiling and control panel. It had a sour odor. The refrigerator freezer section had 2-3 inches of ice with embedded containers of food and the door was not functional from ice obstruction.</p> <p>3. On the West unit the medication room sink had a thick dried layer of white matter with a rubber band and soil dried in and loose gray debris on top. The sink fixture had accumulated metal flake and mineral deposits with deteriorated finish decomposition. The floor and counters were heavily soiled and stained and scattered with loose soil.</p> <p>The West Pantry walls had spattered dried food. There were marks from tape glue with adhering soil on cabinets and wall. The floor was heavily soiled charcoal colored deposits especially along floor edges and corners and on floor register. The microwave had a coating of food soil on the ceiling. The refrigerator freezer compartment had an accumulation of ice obstructing the door from operating.</p>				

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	<p>The nurses station chair upholstery was ripped with exposed stuffing and heavily stained and soiled. The seat was sitting at an angle. RN #4 had stated on 6/08 at 9:45 A.M. "I hate to sit in it. It throws my back forward and hurts my back. I have to use a stool." The floor finish of the nurses station was worn off, leaving wear area of floor without patten. The floor of the station including area under the desk had accumulated charcoal soil especially in corners and edges.</p> <p>4. The facility entryway was carpeted in the center of the facility, extending down to double doors on each hall. The carpet was chestnut colored with a pattern. It was heavily soiled dark gray in areas, obscuring the pattern. It had a variety of stains from 4 inch areas to 10 inch areas scattered on it's surface. There were threads unraveled in a loose fringe horizontally across the halls where carpet pieces had been joined.</p> <p>5. On 6/08 9:55 A. M. the Director of Nursing was interviewed regarding cleaning responsibility for the medication room. She indicated the housekeepers were cleaning the medication rooms(under licensed</p>			

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	<p>nurse supervision). She indicated the pantry cleaning was also the responsibility of housekeepers.</p> <p>On 6/08/12 at 9:57 A.M. Housekeeper # 2 indicated her department never had cleaned the medication rooms only the pantries and nurses stations on each unit.</p> <p>On 6/08/12 at 10 :00 A.M. the Housekeeping Supervisor (HS) indicated the housekeepers were not supposed to clean the medication rooms as the nurses were responsible for that. The pantries on both units however, were on the deep clean schedule of housekeepers as were the nurses stations and were a housekeeping responsibility.</p> <p>Review of deep cleaning logging for the past 4 weeks on both East and West units included pantry and Nurses station deep cleaning every other weekend. It had not been initialed as completed for either unit in the past month. The HS indicated she did not know why pantries were not being cleaned. She indicated the housekeepers did for sure clean the tops of the fencing dividers on both units but did not know why they were leaving the bottoms uncleaned. She indicated the carpet was cleaned</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>professionally from an outside service which was called whenever it needed to be but as far as she knew, they were not due to come.</p> <p>The HS indicated she had just assumed her position as supervisor and had lost an employee last week. She attributed some of the departments to those factors.</p> <p>3.1-19(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2012	
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F9999	<p>1. "Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: ... (6) position in the facility and job description..."</p> <p>This state rule not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure employee files included a job descriptions for 2 of 5 employee files reviewed. Housekeeper employee #1, Maintenance employee #2</p> <p>Findings include:</p> <p>On 6/8/12 at 1: 15 P.M., 5 facility employee files were reviewed. Housekeeper employee #1's file indicated a start date of employment of 3/13/11. Documentation was lacking in this employee file of a job description. On 6/8/12 at 1:17 P.M. the Administrator was interviewed in regard to the lack of a job description for this housekeeping employee. The Administrator at this time indicated the documentation was lacking.</p> <p>On 6/8/12 at 1:15 P. M, Maintenance employee #2's file was reviewed. His</p>	F9999	<p>1. It is the policy of this facility to maintain current and accurate personnel records for all employees. The personnel records for all employees will include the position in the facility and job description. The record will also include documentation of specific job skills.2. Affected Employees include Housekeeper #1 and Maintenance Employee #2.3. A job description will be implemented for housekeeping and Maintenance and they will sign and acknowledge job description upon hire. A skills checklist will be provided and they will sign and acknowledge once proper training has been provided.4. The Administrator will ensure compliance by Monitoring New Employee Files weekly for 2 months and then monthly.Addendum: The housekeeper and Maintenance Man have received job descriptions and skills checklists. Employee audits will be completed by the end of next week.</p>	07/08/2012			

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	<p>start date of employment was documented as 3/1/12. Documentation was lacking of a job description. On 6/8/12 at 1:17 P.M., the Administrator at this time indicated his job description was lacking in his employee file. She also indicated the facility did not have a job description form for maintenance staff and it would have to be developed.</p> <p>3.1-14(q)(6)</p> <p>2. "Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: "(7) Documentation of orientation to the facility and to the specific job skills..."</p> <p>This state rule not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure employee files included a specific orientation for 2 of 5 employee files reviewed. Housekeeper employee #1, Maintenance employee #2</p> <p>On 6/8/12 at 1:15 P.M., 5 facility employee files were reviewed. Housekeeper employee #1's file indicated a start date of employment of 3/13/11.</p>						

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	<p>Documentation was lacking in this employee file of a specific housekeeping job orientation. On 6/8/12 at 1:17 P.M., the Administrator was interviewed in regard to the lack of a specific housekeeping job orientation. The Administrator indicated at this time the employee had gone thru the training but the documentation was lacking.</p> <p>On 6/8/12 at 1:15 P.M., Maintenance employee #2's file was reviewed. His start date of employment was documented as 3/1/12. Documentation was lacking of a specific maintenance's job orientation. On 6/8/12 at 1:17 P.M., the Administrator indicated a specific maintenance orientation was lacking in his employee file. She also indicated the facility did not have a specific orientation form for maintenance and it would have to be developed.</p> <p>3.1-14(q)(7)</p>				