STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 00 B. WING	02/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	7301 E 16TH ST INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00221476. Complaint IN00221476- Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 31, February 1, 2, 3, and 6, 2017 Facility number: 000227 Provider number: 155334 AIM number: 100267520 Census bed type: SNF/NF: 137 Total: 137 Census payor type: Medicare: 23 Medicaid: 97 Other: 17 Total: 137 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Attached is the completed Plan of Correction for our Annual Recertification Survey dated February 6,2017. We request that our plan of correction be considered for a paper compliance desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on February 13, 2017			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident			

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	assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure an accuracy of the MDS assessment regarding wandering to a dangerous place for 1 of 2 residents reviewed for MDS accuracy. (Resident 229) Findings include: The clinical record for Resident 229 was reviewed on 2/2/17 at 8:42 a.m. Resident 229's admission was on 8/12/16. The diagnosis for Resident 229 included, but was not limited to, Parkinson's disease. The 8/19/16 MDS Admission assessment indicated Resident 229's wandering placed him at significant risk of getting to a potentially dangerous place. "...A. Physical behavior...B. Verbal behavior symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others.)..Behavior not exhibited...C. Other behavior symptoms not directed toward others (e.g. ..pacing, rummaging,..verbal/vocal symptoms like screaming, disruptive sounds...behavior not exhibited..."	F 0278	1.Resident identified as 229 did not reside in the facility at the time of this survey and no harm came to the resident. Resident 229 admission record has been modified to reflect that the resident was wandering. 2.All other residents residing in the facility that have the potential to be affected have had their MDS assessment reviewed and any inaccuracy has been corrected and modifications have been made. 3.Education has been completed with the Interdisciplinary team that is directly responsible for the accuracy of the MDS process, which includes but not limited to the appropriate RAI definition of wandering. 4.The MDS coordinator/Designee will review the accuracy of each section of the MDS on 3 completed MDSes 5 days a week for 30 days, then twice weekly for 30 days, and 3 assessments monthly as a ongoing practice at the facility. All findings will be reported to the PI committee monthly. The PI committee will determine when 100% compliance is achieved and the need for increased review is needed.	03/01/2017

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	An "Unsafe Wandering Risk Evaluation dated 8/12/16, indicated "...A. Risk Factors... A2. Is the patient cognitively impaired...? yes (marked). A3. Does the patient frequently pace or wander in areas/other residents' rooms without purpose? no (marked). A4. Does the patient have impaired decision-making skills that decrease his/her awareness of safety? yes (marked). A5. Does the patient express a desire to leave the center? yes (marked). A6. Does the patient express anger at being placed in a nursing home? yes (marked). B. Summary and Recommendations B1. Patient is at risk for wandering?..yes (marked) ..B1a. If Yes, reason for decision to consider at risk for wandering: Res (Resident 229) showing wandering behaviors. B2. Patient is at risk for elopement? no (marked)...B4. Is patient at risk for wandering and/or elopement? yes (marked).." A progress note dated 8/12/16, indicated "...Family was at bedside earlier and resident stated 'I'll stay and give this place a change.'..." An interview was conducted with the Director of Nursing Services (DNS) on 2/3/17 at 8:44 a.m. She reported Resident 229 on admission was very angry about having to be at the facility			

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	and had expressed he wanted to leave. DNS reported an unsafe wandering risk assessment was completed at that time. She indicated the staff educated him about his stay, and he then agreed to remain at the facility. DNS stated after talking with Resident 229 there was no other concerns. She reported Resident 229 had not gone in other residents rooms or gone to any doors. Section E1000A of the RAI (Resident Assessment Instrument) was reviewed with the Social Services Manager 2 on 2/3/17 at 10:45 a.m. It indicated, "Code 1, yes: if the wandering places the resident at significant risk of getting to a dangerous place (e.g., wandering outside the facility where there is heavy traffic) or encountering a dangerous situation (e.g. wandering into the room of another resident with dementia who is known to become physically aggressive toward intruders)..." At that time, Social Services Manager 2 stated she had noticed on 8/12/16, Resident 229 had passed her office in the hallway, and she had overheard him say "he was leaving". Social Services Manager 2 reported she had gotten up and intervened Resident 229 in the middle of the hallway. She reported Resident 229 was not in the lobby by the door nor was he going into other residents rooms. She indicated she			

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	had coded Resident 229 was at risk for wandering to a significant dangerous place due to the busy road outside. An interview was conducted with the Administrator on 2/6/17 at 9:23 a.m. She indicated the front door remains locked with a push key pad to exit. She also stated a staff person was present at the front desk usually starting around 9:00 a.m., until 7:30 p.m. 3.1-31(g)			
F 0412 SS=D Bldg. 00	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility-			

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	(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to follow up with a dental recommendations for 1 of 1 resident reviewed for preadmission screening and resident review and 2 of 3 residents reviewed for dental. (Residents 78, 140, & 215) Findings include: 1. The clinical record for Resident 140 was reviewed on 2/6/17 at 11:00 a.m. The diagnoses for Resident 140 included, but were not limited to, unspecified intellectual disabilities.	F 0412	1.Resident 140 was not harmed by the deficient practice. Resident 140 has a dental procedure set for 2/22/2017 for extraction of her teeth. Resident 78 and 215 were not harmed by the deficient practice and both residents are on the list to be seen by the dentist upon the next visit to the facility on 3/9/2017. 2.All other residents that have the potential to be affected have been interviewed in regards to dental needs/request. Any resident that is not interviewable has had an oral assessment and the family has been interviewed in regards to the patients oral care needs/concerns. Any resident	03/01/2017

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	The 9/22/16 Pre-Admission Screening/Annual Review Certification For Nursing Facility Services indicated Resident 140 had a developmental disability and required total assistance for oral hygiene tasks. There was a recommendation that read, "(Name of Resident 140) benefits from routine physical, dental, vision, and hearing evaluations as well as access to any specialized medical services as indicated." The dental care plan, revised 2/1/17, read, "Res (resident) will be seen by dentist as needed." The 1/29/16 Dental Exam read, "Tooth Notes: 1-29-16 periodic. Referral written to extract all remaining due to gross decay....Treatment Plan...Schedule: 3 Months - 90 Days Referral Follow Up." There was no information in the clinical record indicating follow up to the above teeth extraction referral. The 8/2/16 Dental Exam read, "Lower rampant carries. Tooth Notes: Periodic Done today 8-2-16 Pt (patient) Asympt (asymptomatic) Rampant caries (sic) remaining dentition. Pt has been referred for TX (treatment)...Debris Level:		found to have oral issues will be put on the list to see the dentist upon his next scheduled visit on 3/9/2017 and/or 3/15/2017. 3.The facility has met with the Senior Well representative and going forward a list will be provided to the SSD/DNS/Designee of any resident that needs immediate dental service along with a list of residents that require a follow up visit. Senior Well will automatically put any resident that needs a follow up visit on the list to be seen on the next visit or on the list for a timed visit, i.e. the next 90 days. The SSD/UM/DNS/Designee will read the notes from each visit upon receiving them for any information i.e. follow up, extraction, concerns and ensure that the resident is either on the list or set up for an appointment by the outside dental service. 4.The DNS/SSD/Designee will complete an audit of 10 residents per visit after each visit for 3 months, then 5 residents each month for 3 months, then 5 residents every other month x 6 months. A random sample will of 10 residents will be interviewed monthly to ensure that their oral care needs are being met. All findings will be reported to the PI committee monthly. The PI committee will determine when 100% compliance is achieved or if ongoing monitoring is needed.	

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	Heavy..." An interview was conducted with SSM (Social Services Manager) 1 on 2/6/17 at 12:25 p.m. She stated, "I looked into it, and she (Resident 140) has not been referred out. The referral came in January (2016). The August note didn't come with a referral, but referenced the past referral. I'm going to call the daughter and see how she feels about it, and see if they have a preference for a dentist. I think we identified that moving forward, we need to follow up with the referrals ourselves. I noticed the 3 month follow up recommendation from the January (2016) note, and that wasn't done either." An observation of Resident 140's teeth was made on 2/6/17 at 12:55 p.m. They were blackish gray looking. 2. The clinical record for Resident 78 was reviewed on 2/2/17 at 11:48 a.m. The diagnosis for Resident 28 included, but was not limited to, diabetes mellitus. A dental exam dated 8/2/16, indicated Resident 78's denture fit was fair. The tooth notes indicated the visit was Resident 78's initial assessment. Resident 78 had upper dentures that was cleaned on this visit, but the dentist had "limited view" of her denture. It indicated the			

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	dentist was unable to remove the upper denture due to Resident 78 was not cooperative. The dentist recommendation indicated "..Schedule: Next Visit - Follow Up. Notes: FOLLOW UP AND TRY TO REMOVE PTS (patients) C/ (upper denture) AND CHECK C/ (upper denture)." A physician order dated 1/20/17, indicated staff was to change Resident 78's diet from mechanical soft to pureed due to dentures needed to be refitted. A progress note dated 1/20/17, stated "Resident diet changed as safety precaution due to dentures not fitting properly..." The dentist visit lists were provided by Social Services Manager 1 on 2/2/17 at 1:15 p.m. The dentist had been in the facility to see residents in September, October and January. Resident 78 had not been on the lists or seen for her follow-up exam. A interview was conducted with Social Services Manager 2 on 2/6/17 at 9:17 a.m. She stated the dentist comes to the facility every other month. An interview was conducted with Social Services Manager 1 on 2/6/17 at 12:29			

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	p.m. She reported there was some confusion on who would address residents' dental follow ups, referrals, and recommendations. She stated moving forward she would ask for a list of dental recommendations to follow up themselves. A dental policy was provided by the Director Nursing Services (DNS) on 2/6/17 at 11:02 a.m. It indicated "..Policy Patients are assisted with obtaining routine dental services and 24-hour emergency dental services. Definition. Routine Dental Services. An annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, detailed radiographs as needed, dental cleaning, fillings (new and repairs), minor detailed plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures, i.e., taking impressions for dentures and fitting dentures. Emergency Dental Services. Services needed to treat an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth, or any other problem of the oral cavity by a dentist that requires immediate attention..Procedure...3. The center, if necessary, assists the patient; a. making appointments;...4. The center refers patients with lost or damaged dentures to a dentist as soon as the dentures are lost			

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	or damaged, within reason..." 3. The clinical record for Resident 215 was reviewed on 2/2/17 at 9:23 a.m. The diagnoses included, but were not limited to, diabetes mellitus, flaccid hemiplegia affecting left nondominant side, and cerebral infarction. Resident 215's admission date was 6/20/16. An interview was conducted with Resident 215 on 1/31/17 at 2:50 p.m. She indicated she is missing her lower front tooth and she is supposed to follow-up with the dentist but she has not. A quarterly MDS (Minimum Data Set) assessment, completed on 9/27/16, noted a BIMS (Brief Interview for Mental Status) score of 15. This indicated Resident 215 is cognitively intact. A document titled "Dental Exam" was provided by Unit Manager 3 on 2/2/17 at 10:15 a.m. The form stated the following, "...Exam Summary...09/08/2016...Initial/comprehensive oral exam...Recommended Treatment Plan...Schedule: 3 months - 90 Days Follow Up...." No other dental consults were found in Resident 215's chart. An interview was conducted with Social Service Manager 1 on 2/2/17 at 1:08 p.m. She indicated nursing staff will follow-up with the recommendations from the			

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	dentist and they will write their name down on a list for Social Service Manager 1 to add that resident to the list to be seen by the dentist. An interview was conducted with Social Service Manager 2 on 2/3/17 at 10:10 a.m. She indicated the [name of dental services] will add residents to their list to be seen based on the recommendations for follow-up. The nurse who is seeing those recommendations for follow up will add that resident to the list to be seen by the dentist. An interview was conducted with the Director of Nursing Services (DNS) on 2/3/17 at 2:12 p.m. She indicated Social Services obtains the report from [name of dental services] to follow-up on which residents need to be seen again by the dentist. An interview was conducted with the DNS on 2/6/17 at 8:30 a.m. She indicated Resident 215 must have been missed and she was not seen by the dentist as recommended for follow-up. A policy titled "NCD Dental Services", Release Date: 09/21/2016, was provided by the DNS on 2/6/17 at 11:02 a.m. The policy indicated the following, "...Policy...Patients are assisted with obtaining routine dental services and 24-hour emergency dental			

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	services...Procedure...3. The center, if necessary, assists the patient:...a. In making appointments; and...b. Arranging for transportation to and from the dentist's office...." 3.1-24(a)(1) 3.1-24(a)(3)			
F 0428 SS=D Bldg. 00	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.			

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	(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on interview and record review, the facility failed to timely address a pharmacy recommendations for 2 of 5 residents reviewed for unnecessary medication. (Residents 50 & 251) Findings include: 1. The clinical record for Resident 50	F 0428	1.Resident 50 was not harmed by the deficient practice. The re-evaluation was reviewed within the 2 weeks and the MD addressed the pharmacy recommendation upon her return to the facility. The medication could not be adjusted based off of a pharmacy recommendation and required a physician order. Upon receiving the physician order the	03/01/2017

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	was reviewed on 1/31/17 at 2:32 p.m. The diagnoses for Resident 50 included, but were not limited to, dementia with behavioral disturbance. He was admitted to the facility on 11/28/16. The 12/8/16 pharmacy Consultation Report read, "(Name of Resident 50) was recently admitted with an order for an antipsychotic medication Risperdal 0.5 mg Once Daily for Dementia with Behavioral Disturbance which requires re-evaluation of use within two weeks. Recommendation: Please consider a gradual dose reduction or document continued need at current dose noting resident - specific reasons for continuation which should include risk-benefit analysis..." The January 2017 MAR (medication administration record) indicated 0.5 mg of Risperdal continued to be administered daily until 1/10/17. Resident 50 had his next monthly pharmacy review on 1/5/17, prior to receiving a response to the 12/8/16 pharmacy recommendation. The 1/10/17 Physician's Response to the 12/8/16 pharmacy recommendation read, "I accept the recommendation (s) above WITH THE FOLLOWING		medication was changed to a lower dose. Resident 251 was not harmed by the deficient practice. The pharmacy recommendation was reviewed by the nurse practitioner and his medication was discontinued per the new physician order. 2.All other residents that have the potential to be affected have been reviewed and all pharmacy recommendations have been completed, reviewed and signed by MD/NP. 3.The facility and pharmacist have agreed that the pharmacy recommendations will arrive via email to the DNS within 24-48 hours and will be addressed with 1-2 weeks of receiving pending the MD/NP availability to the facility. Should the MD/NP not be available within that time frame they will address the recommendations upon their next scheduled visit to the facilityor not to exceed 30 days. Should the MD/NP not be available in this time frame the recommendations will be called into the on call MD/NP to be answered and appropriate orders obtained. The company policy does state that the facility is to encourage the MD to respond to the recommendations with 30-60 days. Any recommendation that has the potential to place a resident in harm or has the potential to have a negative impact on the resident will be relayed to the DNS/Designee	

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	MODIFICATIONS: ...(symbol for "decrease") Risperdal to 0.25 mg QD (everyday) for Dementia (symbol for "with") Behavioral Disturbance." The physician response was signed by the physician on 1/10/17, 33 days after the recommendation was made. During an interview with the Director of Nursing Services (DNS), on 2/3/17 at 2:25 p.m., the DNS indicated she was unaware of each time the pharmacist was in the building, since there was not a set schedule. By only pulling the recommendations once a month, at the end of the month, it was a good way not to miss any recommendations and have duplicate recommendations. The date on the recommendation was only for billing purposes. On 2/3/17 at 2:49 p.m., the District Nurse indicated the facility policy does not say to act immediately or within any specific timeframe. If the pharmacist's last day in the building was in the middle of the month and we knew it was her last day in the building for the month, we could run the report before the end of the month. At 1:07 p.m., on 2/6/17, Nurse Practitioner 6 indicated the Physician liked to be involved in the decisions regarding pharmacy recommendations		prior to the pharmacist leaving the building and that concern will be called in to the MD/NP before end of business day. 4.The DNS/Designee will review all pharmacy recommendations for completion and timeliness as an ongoing practice in the facility. All findings will be reported to the PI committee monthly. The PI committee will determine when 100% compliance is achieved or if a action plan needs to be put in place.	

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	and with her schedule, reviewing the recommendations monthly worked best. If there was an urgent matter that needed to be addressed, the Pharmacist could notify me or the facility right away, since I am in the facility everyday during the week. Nurse Practitioner 6 indicated an acceptable timeframe to review pharmacy recommendations was monthly. An interview was conducted via speaker phone with Pharmacist 5, on 2/6/17 at 12:10 p.m. The DNS was present for this interview. Pharmacist 5 indicated she conducted pharmacy reviews at the facility 3 times a month, usually on Thursdays. She indicated the recommendations were uploaded to a website for the DNS to access the day of her visit or by the following day. She indicated she sat at the nurse's station when conducting reviews, and either spoke with the unit manager or the DNS prior to leaving the facility. She indicated the recommendation date on the consultation report was the day of her facility visit. 2. The clinical record for Resident 251 was reviewed on 2/3/17 at 11:45 a.m. The diagnoses for Resident 251 included, but were not limited to, coronary artery disease, anxiety, and depression. A Pharmacy Recommendation, dated			

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	12/15/16, indicated, "[name of resident 251] receives Eliquis 5 mg twice daily and is also receiving aspirin 325 mg once daily. Last hemoglobin [lab test that measures oxygen levels in the blood] 11/11/16 was 7.7. Recommendation: Please re-evaluate continued use of this combination as it increases the risk of bleeding...Rationale for Recommendation: Concomitant use of anticoagulants, antiplatelets, or NSAIDs with Eliquis results in an increased risk of bleeding. The manufacturer recommends against the concomitant use of anticoagulants and states that long-term safety of concomitant aspirin or NSAID use has not been studied...." The January 2017 MAR (medication administration record) indicated aspirin was administered 1/1/17-1/12/17. The 1/12/17 prescriber response to the 12/15/16 recommendation had a handwritten note, "DC ASA [discontinue aspirin]" and was signed by Nurse Practitioner #6. The prescriber response was signed by Nurse Practitioner #6 on 1/12/17, 28 days after the recommendation was made. There was no other indication in the clinical record addressing the review of the pharmacy recommendation prior to 1/12/17.			

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	During an interview with the Director of Nursing Services (DNS), on 2/3/17 at 2:25 p.m., the DNS indicated she was unaware of each time the pharmacist was in the building, since there was not a set schedule. By only pulling the recommendations once a month, at the end of the month, it was a good way not to miss any recommendations and have duplicate recommendations. The date on the recommendation was only for billing purposes. On 2/3/17 at 2:49 p.m., the District Nurse indicated the facility policy does not say to act immediately or within any specific timeframe. If the pharmacist's last day in the building was in the middle of the month and we knew it was her last day in the building for the month, we could run the report before the end of the month. At 1:07 p.m., on 2/6/17, Nurse Practitioner #6 indicated the Physician liked to be involved in the decisions regarding pharmacy recommendations and with her schedule, reviewing the recommendations monthly worked best. If there was an urgent matter that needed to be addressed, the Pharmacist could notify me or the facility right away, since I am in the facility everyday during the week. Nurse Practitioner #6 indicated an			

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	acceptable timeframe to review pharmacy recommendations was monthly. A policy titled, Medication Regimen Review, dated 12/1/07 was received from the District Nurse on 2/3/17 at 2:50 p.m. The policy indicated, "...Facility should independently review each resident's mediation regiment directly from the resident's medical chart and with Interdisciplinary Care Team members, resident, or Responsible Party, as needed. 6. Facility should ensure that Facility Physicians/Prescriber are provided with copies of the MRRs [medication regimen review]. 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected...." 3.1-25(i)			

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F 0465 SS=E Bldg. 00	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation, interview, and record review, the failed to maintain resident bathrooms in good repair for 5 resident's bathrooms of 40 resident's bathrooms reviewed. (Residents 9,12, 58, 251 & 274) Findings include: 1. An environmental tour was conducted with the Maintenance Director, on 2/6/17 at 11:45 a.m. The Maintenance Director indicated the facility staff was to notify environmental services of maintenance concerns. He also indicated	F 0465	All of the 5 resident bathrooms have been repaired. Resident #58's and resident #12's bathroom was grouted and painted. Resident #251's and resident #9's faucet was replaced, Resident # 274's faucet had an aerator put on the end of the faucet to cut down on the force of water coming out of faucet. A room by room inspection was completed on all resident bathrooms checking for any faucets that leak or need replaced. Room by room inspection was also completed to find any walls in bathrooms that	03/01/2017

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	environmental services were able to audit each room on average about once a month to ensure the room and bathroom was in good repair . During the following observations of Resident 58's bathroom, paint was noted to be bubbling away from the wall and peeling up from the trim along the floor: 1/31/17 at 2:54 p.m., 2/6/17 at 9:37 a.m., & 2/6/17 at 11:50 a.m. During an interview and observation with the Maintenance Director, on 2/6/17 at 11:50 a.m., the Maintenance Director indicated he was not notified of the condition of the bathroom wall. He indicated the wall needed to be repaired. 2. During the following observations of Resident 12's bathroom wall, a fist size section of missing/gouged paint with finger length sections of missing/gouged paint was observed: 1/31/17 at 1:10 p.m., 2/6//17 at 10:03 a.m., & 2/6/17 at 11:45 a.m. During an interview and observation with the Maintenance Director, on 2/6/17 at 11:45 a.m., the Maintenance Director indicated he was not notified of the condition of the bathroom wall. He indicated the wall needed to be repaired.		had gouges or missing paint. Room inspections will now be done twice a month instead of monthly by maintenance Director or his assistant. Staff have been re-educated on putting items needing repaired into the TELS system for maintenance to address. Department Managers are also told to check residents rooms and bathrooms while doing their Angel Care Rounds and to enter any findings on TELS for maintenance. Maintenance checks TELS each day and completes repairs as needed and the work order is marked as completed. ED will review TELs weekly to see that work orders are being placed into TELS and that repairs are being made. ED and Maintenance Director will complete environmental rounds on a monthly basis together to assure that environmental issues have been addressed. All findings will be reported to the PI committee monthly. The PI committee will determine when 100% compliance is achieved and the need for increased review is needed.	

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3. During the following observations of Resident 274's bathroom, a burst of water came out of the faucet when turned on and required one to back up to avoid getting sprayed with water: 2/1/17 at 12:00 p.m., 2/6/17 at 9:39 a.m., & 2/6/17 at 11:55 a.m.

During an interview and observation with the Maintenance Director, on 2/6/17 at 11:55 a.m., the Maintenance Director indicated the faucet was recently replaced, around 2 months ago. He indicated the faucet was missing a piece that needed to be replaced, so the faucet wouldn't spray past the sink.

4. During the following observations, Resident 9's bathroom sink was noted to leak from both handles when turned on and there was a build-up of white residue all over the faucet: 1/31/17 at 3:05 p.m., 2/6/17 at 9:56 a.m., & 2/6/17 at 11:55 a.m.

During an interview with Resident 9, on 1/31/17 at 3:05 p.m., she indicated her faucet had been leaking and observed as above, since she moved into the facility.

The Quarterly MDS (minimum data set) assessment, dated 1/12/17, indicated Resident 9 was admitted on 10/8/16 to

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	her current room and had a BIMS (brief interview of mental status) of 15, which was indicative of cognitively intact. During an observation and interview with the Maintenance Director, on 2/6/17 at 11:55 a.m., the Maintenance Director indicated he was unaware of the condition of the faucet/faucet handles and he will replace the faucet. 5. During the following observations, Resident 251's bathroom sink was noted to leak from both handles when turned on and there was a build-up of white residue all over the faucet: 1/31/17 at 3:14 p.m., 2/6/17 at 9:57 a.m., & 2/6/17 at 11:57 a.m. During an observation and interview with the Maintenance Director, on 2/6/17 at 11:57 a.m., the Maintenance Director indicated he was unaware of the condition of the faucet/faucet handles and he will replace the faucet. A policy titled, ...Patient's Environment, dated 5/28/15, was received from the Maintenance Director on 2/6/17 at 12:24 p.m. The policy indicated, "A safe, clean, comfortable and homelike environment is provided that allows the patient to use his or her personal belongings to the extent possible...3.			

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	Housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior...." 3.1-19(f)			