STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOOGOOTEE NURSING CENTER	12802 E US HWY 50 LOOGOOTEE, IN 47553

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00224892. Complaint IN00224892- Unsubstantiated due to lack of evidence. Survey dates: March 13, 14, 15, 16, 17, & 18, 2017 Facility number: 000164 Provider number: 155263 AIM number: 10028994 Census bed type SNF/NF: 32 Total: 32 Census payor type Medicare: 2 Medicaid: 27 Other: 3 Total: 32 These deficiencies reflect State findings cited in accordance with 16.2-3.1. Quality review completed on March 22, 2017.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 04/07/17 to the state findings of the Recertification and State Licensure Survey. We respectfully request paper compliance.	

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

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F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-			

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	(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on observation, interview, and record review, the facility failed to ensure the physician and family were notified of a resident's significant change in weight for 1 of 23 residents who met the criteria for nutrition. (Resident 42) Findings include: During an observation on 3/17/17 between 12:05 P.M. and 12:35 P.M., Resident 42 was sitting at a table in the dining room with CNA 1 and 4 other residents. Resident 42 was feeding himself. The clinical record of Resident 42 was reviewed on 3/16/17 at 1:30 P.M. The record indicated Resident 42 was admitted to the facility on 12/20/16 with a weight of 212 pounds. The diagnoses of Resident 42 included but were not limited to, stroke, chronic obstructive pulmonary disease, weakness, dementia,	F 0157	F157 It is the practice of this facility to immediately inform the resident, consult with resident's physician, and notify, the resident's representative when there is a change in the resident's condition. 1. Corrective action taken for those residents found to have been affected by the deficient practice for F157 SS=D. Weights were identified for resident # 42 using the weekly and monthly weight flow sheets. Resident's physician and the resident's son were notified on 3/17/17, of a weight loss of 5.9% on 2-1-17, weight loss of 5.3% in 30 days and 10.5% weight loss in 90 days noted on 3/1/17. Care plan updated to identify that resident will remain on weekly weights, resident to be assisted with all meals, Sugar Free Magic Cups provided at lunch and dinner, whole milk provided meals. Resident's intake and weights will be monitored weekly at the IDT SWAT meeting. IDT SWAT Meeting held 3/23/17 to identify resident as being at	04/07/2017

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	and diabetes. A "WEEKLY WEIGHTS 2017: form read as follows, "... 2/14/17...194.4... 2/21/17...hosp [hospital]... 2/28/17...184.8... 3/14/17...184.6..." The Quarterly MDS (Minimum Data Set) assessment dated 1/25/17 indicated Resident 42 experienced severe cognitive impairment, required the extensive assist of 2 staff for transfer, bed mobility, toileting, and needed assistance with eating. A care plan dated 1/25/17 indicated, "...ALTERATION IN NUTRITION D/T [due to] CCHO [consistent or controlled carbohydrate diet] NASDIET [sic] [sodium restricted diet] WITH A MECH [mechanical]ALTER DIET...GOAL...MAINTAIN C.B.W. =/- 5# [pounds] PER MONTH...INTERVENTIONS... MECH SOFT, CCHO, NAS DIET... HONOR LIKES AND DISLIKES... MONITOR MONTHLY WEIGHTS... VITAMINS, MINERALS, SUPPLEMENT AS ORDERED...SNACK BETWEEN MEALS..."		nutritional risk related to weight loss. Attending meeting were the DON, ADON, and Dietary Manager. No other residents were identified as having issues related to notification of changes. 2. How other residents having potential to be affected by the same practice will be identified and what corrective action will be taken. A house-wide audit of all resident's weight was completed. Other residents having a significant weight loss were identified, placed on weekly weight monitoring, and discussed during the SWAT meeting on 3/29/17. These residents, residents' physicians and family members were notified of weight loss, interventions are in place to help prevent further weight loss. Residents will be identified by the weekly and monthly weight records for need of resident, family, and physician notification of weight loss. Weekly weights will be discussed by IDT SWAT team weekly for identification of weight loss and need for interventions. Nursing staff were given an in-service by DON on 3/24/17 regarding appropriate notification and documentation of changes in condition, of residents. 3. Measure and systematic changes will be made to ensure deficient practice does not recur. The DON and/or designee will audit weekly weights on Tuesdays for	

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	The "ALTERATION IN NUTRITION" care plan was reviewed on 3/7/17 and 3/13/17 and lacked documentation of new interventions. A "MEAL CONSUMPTION RECORD" dated February and March 2017 indicated Resident 42 had not taken any of the snacks offered at bed time. A "NUTRITION SERVICE PROGRESS NOTE" dated 1/25/17 read as follows, "...Wt [weight] on 1/24/17 is 204. Down 9# [pounds] since admission...Res is assia [sic] [assisted] at DR [dining room] table. Taken in 25-75% of meal. Res need to be enc [sic] [encouraged] at mealtimes. Snack between meals...Cont's to monitor res...Care Plan updated..." A "NUTRITION SERVICE PROGRESS NOTE" dated 3/2/17 read as follows, "...Wt 189.8 returned from hospital is down 5.3% in 30 days down 10.5% in 90 days. Snack between meals. If res. refuses to get up for meals. The meal is save [sic] for him when he is ready to eat..." A "NUTRITION SERVICE PROGRESS NOTE" dated 1/25/17 read as follows, "...5 day weight 184.4 down 5% since return...at table for assist at meals...consuming 25-75% of meal. Is		need for reweight and will compare weekly weight with previous weight for weight loss, the DON will communicate to the unit nurses which residents have a significant weight loss so that the unit nurse can promptly notify the resident's physician and responsible party. These audits will be completed every week ongoing. 4. How corrective actions will be monitored to ensure the deficient practice will not recur. The DON and/or designee will audit the chart of residents identified to have weight loss, for documentation relating to notification of weight loss to the resident, their family, and physician. The audits will be completed weekly for four weeks, biweekly for four weeks, monthly for 3 months. An audit tool has been developed by DON to identify dates that audits were conducted. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current care plan revised as warranted. The date that the systemic changes will be completed is 4/07/17	

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	enc [encourage] at mealtimes Snacks between meals, con't [continue] to monitor..." During an interview on 3/16/17 at 10:50 A.M., the Dietician indicated Resident 42 had a 7.7% weight loss in the past 30 days. The monthly weight record was reviewed at that time, and the Dietician indicated that Resident 42 was admitted on 12/20/16 at 212 pounds, February weight was 203 pounds, and March weight was 189.9 pounds. The Dietician indicated that she was going to order for Resident 42 a Magic Cup for lunch and dinner. During an interview on 3/16/17 at 1:36 P.M., the Dietary Manager indicated she should have been notified about Resident 42's significant weight loss. During an interview on 3/16/17 at 1:45 P.M., RN 2 indicated the nurse should notify the Dietary Manager and the physician if a resident experienced a significant weight loss. During an observation on 3/17/17 at 11:30 A.M., the Assistant Director of Nursing weighed Resident 42 in the Bathroom on the East Hall. Resident 42's weight was 184 pounds.			

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	A policy and procedure for "Weight Assessment and Intervention" provided by the Director of Nursing (DON) on 3/7/17 at 10:30 A.M., read as follows, "...A resident triggering a significant weight loss...The physician will...be notified...and documented in the clinical record..." During an interview on 3/17/17 at 1:57 P.M., the DON indicated Resident 42 experienced a significant weight loss and his physician and family should have been notified. 3.1-5(a)(2)			
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.			

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	(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 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 observation, interview, and record review, the facility failed to ensure resident assessments were accurate for 2 of 21 resident assessments reviewed during Stage 2 of the survey. Dental status and antipsychotic medications were coded incorrectly. (Resident 36, Resident 28) Findings include: 1. On 3/14/17 at 9:50 A.M., Resident 36	F 0278	F 278 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The Assessment identified for resident # 36 has been corrected related to the resident's dental status. The Assessment identified for resident # 28 has been corrected and now reflects that the resident received an antipsychotic during the assessment reference period.	04/07/2017

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	indicated he did not have any teeth. Resident 36 was observed to be without teeth. On 3/15/17 at 1:11 P.M., Resident 36's clinical record was reviewed. The Annual MDS (Minimum Data Set) Assessment, dated 8/2/16, indicated Resident #36 had no dental issues. An Oral Assessment Form, dated 7/27/16, indicated Resident 36 had no natural teeth. On 3/15/17 at 2:34 P.M., the MDS Coordinator indicated she had coded the MDS dental section with no issues because the resident had dentures. 2. On 3/15/17 at 12:56 P.M., Resident 28's clinical record was reviewed. The most recent physician's recapitulation orders, signed 2/7/17, included, but was not limited to: Abilify (an antipsychotic medication) 5 mg (milligrams), give one tablet, by mouth, once a day for depression, started on 11/21/16. The December MAR (Medication Administration Record) indicated Resident 28 had received the medication December 2-31, 2016.		These assessments reflect the current condition of residents #36 and # 28. 2. How residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents at the facility have the potential to be affected by the same deficient practice. An audit has been completed by the RN MDS Coordinator employed by the facility on all MDS assessments that have completed in the last 30 days to ensure accuracy. If any errors are identified a corrected MDS will be submitted. Identified residents will have a MDS completed that accurately reflects current resident status on or before 04/03/17. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The RN MDS Coordinator employed at the facility will review Point Click Care's Clinical Training and tutorials on MDS Data Entry for MDS 3.0. The MDS Coordinator is now required to complete all tutorial Point Click Care up-dates pertaining to the MDS 3.0 coding.	

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	The Quarterly MDS Assessment, dated 12/10/16, indicated Resident 28 had not received an antipsychotic medication during the seven day assessment period. On 3/15/17 at 2:28 P.M., the MDS Coordinator indicated she had coded the MDS Assessment incorrectly for the use of antipsychotics. On 3/17/17 at 10:40 A.M., the Administrator provided the "Certifying Accuracy of the Resident Assessment" policy, undated. The policy included, but was not limited to: All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. 3.1-31(d)		4. How the corrective actions will be monitored to ensure the deficient practice will not recur. The DON and/or designee will upon the completion of the MDS, review all assessments for coding accuracy until 100% compliance is achieved for 3 months. The results of the audits will be reported to the HFA at morning meeting. The results will also be reported at the quarterly QA meeting for the next 2 meetings. Date systemic changes will be completed 04/07/17.	
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and			

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	(2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview, and record review, the facility failed to ensure effective interventions were implemented and supervision was provided to prevent falls for 1 of 2 residents who met the criteria for review of falls. (Resident 42) Findings include: During an observation on 3/13/17 at 10:11 A.M., Resident 42 was observed lying on his right side in bed with his eyes closed, in no apparent distress.	F 0323	F323 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. IDT meeting for resident #42 was held on 03/28/17 to discuss falls, safety interventions and condition of resident. Care plans, chart documentation and physician orders reviewed. Care plans updated as needed. Safety interventions in place as per MD orders and Care plans. In attendance at the meeting were the HFA, DON, ADON. Interventions added to the care plan	04/07/2017

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	During an observation on 3/17/17 at 12:35 P.M., Resident 42 was observed sitting in a wheelchair at the nurses' station. During an observation on 3/18/17 at 5:45 P.M., Resident 42 was observed sitting in a wheelchair at the nurses' station. The clinical record of Resident 42 was reviewed on 3/16/17 on 1:30 P.M. The record indicated Resident 42 was admitted 12/20/16. The diagnoses of Resident 42 included, but were not limited to, stroke, chronic obstructive pulmonary disease, weakness, dementia, and diabetes. The Admission MDS (Minimum Data Set) assessment dated 12/30/16 indicated Resident 42 experienced cognitive impairment, required the extensive assistance of two staff for transfers, bed mobility, and toileting. The Quarterly MDS (Minimum Data Set) assessment dated 1/25/17 indicated Resident 42 experienced severe cognitive impairment, required the extensive assistance of two staff for transfers, bed mobility, and toileting. A care plan dated 12/27/16 read as		include; resident will have one on one supervision when restless and attempting to rise from chair or bed unattended, and one on one supervision will be continued until such time that the resident is calm and is not attempting to rise unattended. Resident will be toileted upon rising, before and after meals, and at HS. If resident is awake and restless during night, he will be offered urinal or taken to toilet per his preference. Received physician's order for resident to lie on bedside mat he climbs out of bed and is calm or sleeping on mat. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents in facility have the potential to be affected by the same deficient practice. Current residents who have history of falls within the last 3 months will be re-assessed by the IDT to assure that the plan of care and interventions are useful and effective to help prevent falls by these residents. IDT re-assessments of these residents will be done weekly x 4 and as change of condition occurs. Newly admitted residents who are assessed, as high risk for falls will be provided with assistive safety devices. These approaches will be	

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	follows "...The resident has limited mobility r/t [related to] right sided Stroke and Weakness... Interventions... Resident requires assist of 2 for transfers and ambulation... Resident requires use of 1/2 side rails...Turn and reposition every 2 hours... LOCOMOTION: THE RESIDENT IS TOTALLY DEPENDENT ON (1) STAFF FOR LOCOMOTION USING WHEELCHAIR...Monitoring /document/report PRN [as needed] any s/sx [signs or symptoms] of immobility...fall related injury..." Care Plan updates were as follows, "...12/27/16 alarms to w/c [wheelchair], bed and floor mat... 1/3/17 res to have low bed... 1/4/17 res has bolster [scoop mattress] mattress r/t safety... 1/6/17 ask resident if he wishes to go back to bed... 3/15/17 Tab alarm to w/c..." A care plan dated 12/27/16 read as follows: "...The resident is at a moderate risk for falls r/t Confusion, incontinence, Unaware of safety needs...Interventions... Anticipate and meet the resident's needs... Be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance...		reflected on the resident's care plan and will be implemented accordingly. 3. Measure and systemic changes will be made to ensure deficient practice does not recur. A mandatory in-service for nursing staff relating to Fall Prevention/Free of Accidents/Devices was given by the ADON. Licensed Nurses and CNAs in-serviced on the utmost importance of monitoring residents closely, anticipate their needs, provide supervision, application and monitoring of safety devices placement and function, in order to, assist a resident before a fall occurs. These in-services will be provided at least quarterly, to assure that residents will receive adequate assistance, supervision and that staff will apply appropriate assistive devices when indicated to help prevent falls. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. DON and/or designee will monitor effectiveness of in-services, trainings and compliance during rounds. Any deficient practice will be immediately addressed. DON and/or designee will also monitor compliance by observing Nursing staff during provision of care 3 times weekly for 4 weeks, then 2 times weekly for 3 weeks, then weekly for	

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	155263	A. BUILDING 00 B. WING	03/18/2017

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	Follow facility fall protocol..." Care Plan updates for 3/1/17 were as follows, "...up with assist of x [times] 2... Scoop mattress... Alarms as ordered... 1/2 rails as enabler..." A fall risk assessment completed on 12/30/16 and 1/25/17 indicated Resident 42 experienced intermittent confusion, had a history of falls, and was at a high risk to experience a fall. A fall risk assessment completed on 2/10/17 indicated Resident 42 experienced intermittent confusion, had a history of 3 or more falls in the past 3 months, and was at a high risk to experience a fall..." A nurse's noted dated 12/27/16 10:00 P.M., read as follows: "...Set mobility alarm off numerous x's [times] this evening..." A nurse's note dated 12/28/16 1:30 A.M., read as follows: "...Resident got up from bed in room and walked to west hall bathroom with no assistance..." A nurse's note dated 12/29/16 at 10:00 P.M., read as follows: "...Resting now but has been getting up on his own and		2 weeks to assure that assistive devices are applied to prevent accidents according to Physician orders. Thereafter, DON and ADON will monitor all residents and nursing staff for compliance of use of safety interventions daily, as per usual practice, as rounds are being made throughout facility. If issues are noted, immediate re-education will be provided to the resident and/or staff concerning importance of safety and prevention of fall or injury. Trends regarding the delivery of service, as well as, Plan of Correction and compliance will be shared at the quarterly Quality Assurance Committee Meeting for further recommendation and follow up. The quarterly fall logs will be shared at the QA meetings. Corrective Action Completion Date 04/07/17.	

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	setting off alarms Came out into the hallway with only his brief on..." Fall 1 An "ACCIDENT/INCIDENT REPORT" was provided by the Director of Nursing on 3/17/17 at 9:17 A.M., and it read as follows: "...Location of Incident: room...Date 12/29/16...Time: 10:45 P.M...Description of Incident: Alarm sounding found resident laying up against his bed on the floor. Floor was urine soaked and resident was incont [incontinent] of BM [bowel movement] also..." A nurse's note dated 12/30/16 at 3:45 A.M.: "...Back on alarms...On his knees on the floor will not even try to help himself back up on the bed...took all of people available to pick him up off the floor literally and put him back in the bed..." A nurse's note dated 12/30/16 at 4:10 A.M.: "...sitting in wheelchair near nurses (sic) station..." A nurse's note dated 12/30/16 at 5:15 A.M.: "...trying to get out of wheelchair..." A nurse's note dated 12/30/16 at 6:00 A.M.: "...keeps trying to stand up on his			

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	own. Will not listen to staff when we try to re-direct him..." Fall 2 An "ACCIDENT/INCIDENT REPORT" read as follows: "...Location of Incident: in front of the nurses desk...Date 1/2/17...Time: 7:30 P.M...Description of Incident: Sitting in w/c by nurses desk stood up before nurse got to him he went down on Lt side. Received 2 cm skin tear on Lt. elbow. Skin intact...alarm pressure pad in w/c-did work...Statement: Stood * out of - stepped to left 2 steps off balance and fell onto L side of L arm..." A nurse's note dated 1/8/17 at 3:10 P.M., read as follows: "...Resident up at nurses (sic) station keeps setting off alarms and standing unassisted ..." Fall 3 An "ACCIDENT/INCIDENT REPORT" read as follows: "...Location of Incident: bedroom floor...Date 1/29/17...Time:10:00 A.M....Description of Incident: Floor alarm sounding. CNA went to check an [sic] resident had slid off mat beside low bed and was sitting against door..." Fall 4 An "ACCIDENT/INCIDENT REPORT" read as follows: "...Location of Incident:			

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	resident room...Date 2/10/17...Time:6:00 A.M....Description of Incident: resident found lying on L [left] side on floor between his bed and the bathroom. Bed alarm and alarming floor mat working. Resident with 1.0 cm x 0.5 cm abrasion to left side of forehead..." During an interview on 3/17/17 at 1:15 P.M., the DON indicated Resident 42 was a high risk for falls on admission. At that time, the ADON indicated facility staff would need additional inservicing regarding falls. The policy and procedure for "Falls and Fall Risk, Managing", provided by the DON on 3/17/17 at 10:30 A.M., indicated: "...The staff must implement a new intervention following any fall in an attempt to prevent future falls..." 3.1-45(a)(2)			
F 0465 SS=E Bldg. 00	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON			

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	(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 facility failed to ensure a safe and sanitary environment for 4 of 23 rooms reviewed and 1 of 1 random lift pad observations. Toilet plungers were stored uncovered, urinals were stored uncovered and unlabeled, call light box outlets were loose, and a lift pad was torn. (Room 18, Room 17, Room 21, Room 24, East Hall lift pad) Findings include: 1. On 3/13/17 at 10:26 A.M., Room 18 was observed. In the bathroom, a toilet plunger was uncovered and stored on the floor. The toilet tank lid was observed to be cracked. On 3/16/17 at 10:29 A.M., the same was observed. 2. On 3/14/17 at 10:24 A.M., Room 17 was observed. In the bathroom, a toilet plunger was observed to be stored uncovered on the floor. On 3/16/17 at 10:38 A.M., the same was observed.	F 0465	F 465 It is the practice of this facility to provide a safe, and comfortable environment for residents, staff and the public. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. Resident room bathrooms #17, #18 and #21 toilet plungers and urinal were covered and removed from the bathrooms. b. Resident room #21 bed B was moved/positioned to enable door to close. c. Resident room #24 call light outlet was secured to the wall. d. East hall sit to stand lift pad was removed from service and replaced with a new sit to stand lift pad which is free of wear and tear. e. Resident room bathroom #18 toilet lid replaced with lid free of cracks. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice.	04/07/2017

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	3. On 3/13/17 at 1: 36 P.M., Room 21 was observed. In the bathroom, an unlabeled and uncovered urinal was observed to be stored on the grab bar. A toilet plunger was observed to be stored uncovered on the floor. In the bedroom, Bed B prevented the hallway door from closing. On 3/16/17 at 10:33 A.M., the same was observed. On 3/16/17 at 11:15 A.M., the Administrator indicated toilet plungers should be covered when stored. 4. On 3/14/17 at 1:51 P.M., Room 24 was observed. The call light outlet on the wall was observed to be coming loose from the wall. On 3/16/17 at 10:36 A.M., the same was observed. On 3/16/17 at 10:44 A.M., the Administrator indicated call light outlets should be checked. He further indicated there had been no reports of malfunctioning equipment. 5. On 3/16/17 at 10:58 a.m., a sit to stand lift pad was observed to have the first layer of fabric torn on the East Hall. The ADON indicated while it was normal wear and tear it should be replaced. On 3/17/17 at 10:11 A.M., the Administrator provided the "Care of		a. House wide environmental rounds/audits were completed by the Administrator to ensure all call light boxes are secure, toilet plunger and urinals are covered and removed from resident room bathrooms, resident beds are positioned to enable doors to close, all toilet lids were inspected and no other cracked or damage lids identified and lifting pads are in safe working condition. b. Any repairs or corrective actions will be noted and promptly addressed in a timely manner to ensure compliance. 3. Measure and systemic changes put into place to ensure that the alleged deficient practice does not recur. a. A mandatory in-service for all staff related to a safe and sanitary environment to include the following: b. Staff to be in-serviced the need to report any exposed wiring/electrical issues including loose call light boxes, any damaged or worn equipment, such as cracked toilet lids or worn lift pads. c. Staff will be in-serviced on the proper storage, location and sanitation of plungers and urinals. d. Staff will be in-serviced regarding the position of resident beds enabling doors to close. e. Staff will be in-serviced on system of reporting repairs. Copies of all maintenance repair forms will be given to the Administrator.	

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	Facility Property" policy, undated. The policy included, but was not limited to: All employees are expected and required to exercise due care and safety in the use of all facility property, equipment, and supplies. On 3/17/17 at 10:11 A.M., the Administrator provided the "Maintenance Service" policy, undated. The policy included, but was not limited to: ...Maintaining the building in good repair and free from hazards.... 3.1-19(f)		4. The corrective action will be monitored to ensure the deficient alleged practice does not recur and quality assurance measures put into place. a. Administrator and/or designee will complete environmental rounds three times weekly for 30 days, then two times weekly for 30 days, then weekly ongoing to ensure the facility is providing a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Concerns identified will be noted per maintenance requisition forms and scheduled for repairs accordingly. b. Administrator and/or designee will review any findings and repairs made, if any during the facility's QA meeting. Any revision to the plan will be made, if needed. 5. Corrective action completion date 04/07/17	