STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155778	A. BUILDING 00 B. WING	06/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HEALTHCARE	1212 E MAIN ATTICA, IN 47918

(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. Survey dates: May 31, June 1, 2, 3, 6, and 7, 2016 Facility number: 000323 Provider number: 155778 AIM number: 100288440 Census bed type: SNF/NF: 47 Total: 47 Census payor type: Medicare: 3 Medicaid: 29 Other: 15 Total: 47 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 6/10/16 by 29479.	F 0000	Parkview Healthcare POC submitted by 6/28/2016 The POC corrective actions must be completed by 7-7-2016 We respectfully request a desk review for all tags Please find the plan of correction for Parkview Healthcare for the annual survey dated June 7, 2016. Please review our plan of correction and accept this as proof of compliance. The preparation and/or execution of this plan of correction does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

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

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F 0164 SS=D Bldg. 00	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the			

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	resident. Based on observation, interview, and record review, the facility failed to ensure the residents' rights for personal privacy during medication administration for 2 of 2 residents reviewed for privacy during medication administration (Resident #42 and #56). Findings include: 1. On 6/2/16 at 11:55 a.m., RN (Registered Nurse) #8 administered insulin to Resident #42. While the resident was seated in his bedside chair and was facing the hallway, RN #8 lifted Resident #42's shirt, exposed the resident's abdomen from below the chest to below the navel and administered the insulin injection into his abdomen. The door to the resident's room door was open and staff were observed in the hallway. During an interview on 6/2/16 at 2:18 p.m., RN #8 indicated she should have shut the door for privacy before she administered the insulin injection to Resident #42. On 6/2/16 at 3:20 p.m., review of the resident's Annual Minimum Data Set (MDS) assessment, dated 4/12/16, indicated the resident had no cognitive	F 0164	It is the intent of this facility to ensure resident's rights for personal privacy during medication administration is maintained. F 164 1. RN # 8 and LPN #9 were educated on maintaining resident's rights for personal privacy during medication administration. 2. No other resident identified 3 Licensed nurses were in-serviced on maintaining resident's rights for personal privacy during medication administration 4 DON/Designee will visually observe or by demonstration administration of injections for maintaining resident's rights for personal privacy during medication administration of all licensed nurses DON/designee will visually observe a licensed nurse 3 times weekly for maintaining resident's rights for personal privacy during medication administration. The results of these observations will be reviewed during monthly Quality assurance performance improvement meetings and recommendations will be made to continue observations and how often. 5. Date of completion 7-7-2016	07/07/2016

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	deficit. 2. On 6/2/16 at 12:03 p.m., LPN (Licensed Practical Nurse) #9 administered insulin to Resident #56. With the resident sitting in his bedside chair and facing the hallway, the nurse administered the insulin injection into the resident's abdomen. The door to the resident's room was open and staff were observed in the hallway. At the same time, during an interview, LPN #9 indicated she should have shut the resident's door before she administered the insulin injection. On 6/2/16 at 3:30 p.m., review of the Resident #56's 30-day scheduled Minimum Data Set (MDS) assessment, dated 5/7/16, indicated the resident had no cognitive deficit. A current document titled, "Quality of Life," provided by the ADON (Assistant Director of Nursing) on 6/3/16 at 12:30 p.m., indicated "...Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures...."			

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	3.1-3(p)(2)			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure residents' rights were considered in regard to the volume of a television for 3 of 3 residents observed for dignity. (Resident #18, #35, and #33). Findings include: 1. On 6/1/16 at 1:00 p.m., the television in room #128 was loud and was audible in room #127 across the hallway. On 6/3/16 at 2:47 p.m., the television in room #128 was loudly audible in the hallway 2 doors down from the entrance to the room. On 6/1/16 at 1:15 p.m., during a request for an interview, Resident #18 indicated the interview could not be done in his room because he could not hear because of his roommate's (Resident #6) television.	F 0241	F241 It is the intent of this facility to ensure resident right's are considered in regard to the volume of all televisions. 1 Resident #6 was provided headphones . Resident #6 will be encouraged to see the Audiologist. Resident #6 care plan reviewed and revisions made as it relates to wearing his headphones and seeing an Audiologist. 2. All residents have the potential to be affected. 3 All staff in-serviced on the grievance policy and noise control policy. Nursing staff in-serviced on encouraging Resident #6 to wear headphones or keep television volume at an appropriate level. 4. Social Service person/designee will talk to three alert and oriented residents three times weekly to ensure the volume of the television does not disturb them. Social Service person/designee will take grievance /concern form(s) to next A.M. meeting to review with the Administrator and appropriate department. Resident Council notes will be	07/07/2016

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	On 6/1/16 at 1:24 p.m., Resident #18 indicated Resident #6 plays his television loud all of the time. He indicated he had told the staff, but nothing had been done. The resident indicated he felt he just had to deal with it. The resident indicated, about one year ago, the staff had requested Resident #6 to turn off his television each night at 10:00 p.m. On 6/6/16 at 9:36 a.m., Resident #18's medical record was reviewed. The resident's quarterly minimum data set (MDS) assessment dated 2/23/16, indicated the resident had no cognitive deficits. On 6/6/16 at 10:00 a.m., review of Resident #6's medical record indicated the resident had no care plan for wearing headphones or other options while watching television. The resident's quarterly MDS assessment dated 2/22/16, indicated the resident had no cognitive deficits. 2. On 6/1/16 at 3:50 p.m., Resident # 35 indicated the television across the hallway had been so loud that she and her roommate (Resident #33) could not hear their own television. The resident indicated she understood Resident #6 had the right to play his television as loud as		reviewed in the next A.M. meeting following the Resident Council meeting with the Administrator and the appropriate department. The information gathered from the audits, grievance/ concern form(s) and Resident Council meeting will be reviewed in Quality Assurance and Performance Improvement monthly and recommendations will be made regarding the three times a week audit. 5. Date of completion 7-7-2016	

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	he wanted to, and she just had to deal with it. She indicated it felt like her or her roommate's rights did not matter. She indicated last year the staff requested Resident #6 turn his television off at 10:00 p.m., each night, which had helped, but the television was turned back on early every morning. The resident indicated her roommate had an alarm clipped to her, but with the loud television noise, the staff could not hear it if it went off, so they had to keep their door open, which allowed the television noise to enter their room from across the hall. On 6/6/16 at 9:47 a.m., Resident #35's medical record was reviewed. The resident's quarterly MDS assessment dated 3/18/16, indicated the resident had no cognitive deficit. 3. On 6/1/16 at 3:50 p.m., Resident #33's daughter indicated the door to the resident's room had to be closed when she visited because of the noise from the television across the hall. On 6/6/16 at 11:44 a.m., Resident #33's medical record was reviewed. The resident's 60-day MDS assessment dated 5/13/16, indicated the resident had severe cognitive deficit.			

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	On 6/6/16 at 10:05 a.m., the Administrator indicated grievances and resident council minutes were reviewed monthly and she did not recall complaints of loud television noise. She indicated Resident #18 complained about his roommate's television in the past and staff talked with Resident #6 and the resident kept the television on for background noise. The Administrator indicated the facility encouraged residents and families in the past to use headphones. The Administrator indicated she was not aware if Resident #6 had headphones. On 6/6/16 at 10:29 a.m., the Social Services Director (SSD) indicated residents had not complained to her about television noise. She indicated the facility worked with Resident #6 and his family in the past to get headphones for the resident to wear. She indicated she was not aware the television noise was again an issue. She indicated Resident #6 had headphones, but did not have a care plan for wearing them. On 6/6/16 at 10:51 a.m., CNA #1 indicated she heard Resident #35 complain about the loud television in Resident #6 and #18's room. The CNA indicated she was not aware that Resident #6 had headphones.			

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	A copy of a new headphone utilization care plan for Resident #6, dated 6/6/16, was provided by the SSD on 6/6/16 at 11:39 a.m. A current policy titled, "Resident Rights," dated 8/2011, was provided by the ADON (assistant director of nursing) on 6/6/16 at 1:50 p.m. The policy indicated, "As a resident of this facility, you have the right to a dignified existence...Environment...The facility will provide you with comfortable and safe...sound levels." 3.1-3(T)			
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure an emergency exit door was unobstructed by a bariatric rolling walker for 1 of 2 emergency exits for the Harmony Hall Unit. This deficient practice had the	F 0323	F323 It is the intent of this facility to ensure all emergency exits doors are not obstructed 1. The bariatric rolling walker was moved to the resident's room. 2. All residents have the potential to be affected. 3 All staff was in-serviced on not to obstruct any emergency exit doors. All staff	07/07/2016

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	potential to affect 14 of 14 residents on the Harmony Hall Unit (Residents #60, #7, #36, #11, #21, #14, #4, #10, #5, #46, #35, #33, #18, and #6). Finding includes: On 5/31/16 at 9:46 a.m., a bariatric rolling walker was observed obstructing a portion of one of the double doors used for an emergency exit from the Harmony Hall Unit. On 5/31/16 at 3:45 p.m., a bariatric rolling walker was observed obstructing a portion of one of the double doors used for an emergency exit from the Harmony Hall Unit. On 6/1/16 at 2:18 p.m., a bariatric rolling walker was observed obstructing a portion of one of the double doors used for an emergency exit from the Harmony Hall Unit. On 6/2/16 at 8:57 a.m., a bariatric rolling walker was observed obstructing a portion of one of the double doors used for an emergency exit from the Harmony Hall Unit. On 6/2/16 at 9:02 a.m., MDS (Minimum Data Set) Coordinator #6 was observed moving the bariatric rolling walker from in front of the Harmony Hall's emergency exit door and into room #127. MDS #6 indicated the staff are not supposed to place any equipment in front of		were educated to remove any item obstructing emergency exits and report to the Administrator. 4. Housekeeping supervisor/designee will monitor all exit doors for obstruction 5 times weekly . The results of these audits will be reviewed in the next A.M. meeting. The Quality Assurance and performance improvement committee will review and make recommendations concerning these audits. 5 Date of completion 7-7-2016	

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	emergency exit doors and need to be in-serviced not to place anything in front of the emergency doors. The walker should be placed in the resident's room. On 6/2/16 at 3:15 p.m., the ADM (Administrator) indicated emergency exits should not be obstructed at any time. A facility policy, titled "Parkview Healthcare, Policy: Exit Doors," undated but identified as current and provided by the ADM on 6/2/16 at 3:30 p.m., indicated "...As per the Life Safety Code 7.2.2.5.3.1 Open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress." 3.1-19(c)			
F 0354 SS=C Bldg. 00	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.			

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	The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure employment of a full time designated Director of Nursing (DON) and failed to ensure a Registered Nurse (RN) worked at least 8 consecutive hours a day, 7 days a week. This deficient practice had the potential to affect 47 of 47 residents in the facility. Finding includes: During an interview with the Administrator on 5/31/16 at 11:00 a.m., she indicated the facility did not have a full time DON because the previous DON left without notice. During an interview with the MDS (Minimum Data Set) Coordinator on 6/6/16 at 2:47 p.m., she indicated the previous DON's last day of employment was 5/2/16 and the facility had no full time DON designee. She further indicated a Registered Nurse was not on duty on 5/30/16. A two week nursing schedule for 5/29/16-6/11/16 was reviewed on 6/6/16 at 2:30 p.m. The schedule indicated there was no Registered Nurse on duty for the date of 05/30/16.	F 0354	F354 It is the intent of this facility to ensure the employment of a full time Director of Nursing and to ensure an R.N. works at least 8 consecutive hours a day , 7 days a week. 1. The facility has appointed and Interim D.O.N. . The facility has hired a full time D.O.N. she is currently working part-time and will begin working full-time 7-11-2016 . The facility has hired 2 Registered Nurses to ensure an RN is in the building 8 consecutive hours a day 7 days a week. 2. No residents were identified. 3. The Administrator is aware of the regulatory requirements of a full time DON and RN coverage 8 hours a day 7 days a week. 4. Administrator will monitor licensed nurses' schedules and daily licensed nurses schedules for RN working 8 consecutive hours a day seven days a week. The Quality Assurance Performance Improvement committee will review licensed nurses' schedules for compliance with RN staffing. 5. Date of completion 7-7-2016	07/07/2016

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	On 6/6/26 at 3:20 p.m., the Administrator indicated the facility followed the Indiana guidelines for Registered Nurse and Director of Nursing staffing and should have had a Registered Nurse on duty. 3.1-17(b)(3)			
F 0371 SS=D Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was stored in a safe and sanitary manner in the walk in refrigerator for 1 of 1 kitchen observation. The facility further failed to ensure food was distributed in a safe and sanitary manner for 1 of 1 dining room observation. (Resident #33) Findings include: 1. During an initial kitchen tour on 5/31/16 at 10:20 a.m., two large pans of dessert were observed to be uncovered and unlabeled in the walk in refrigerator.	F 0371	F371 It is the intent of this facility to ensure food is stored in a safe and sanitary manner in the walk-in refrigerator It is the intent of this facility to ensure food is distributed in a safe and sanitary manner A. 1. Dietary staff immediately covered, labeled and dated the two large pans of desserts. 2 No residents were affected 3 All dietary staff was in-serviced by the Dietary Manager/ Registered Dietician on labeling, dating and covering all refrigerated foods. 4. Dietary Manager/ Designee will monitor refrigerated foods for labeling, dating and covering five times weekly The Quality Assurance	07/07/2016

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	During an interview on 5/31/16 at 10:23 a.m., Dietary Aide # 4 indicated the dessert was for the evening meal. She further indicated the pans of dessert should have been covered and labeled in the refrigerator. An undated policy, identified as current, titled, "Refrigerated Storage", provided by the ADON on 6/6/16 at 1:49 p.m., included but not limited to, "...7. All foods with be properly wrapped and/or stored in sealed containers and dated and labeled...." 2. During an observation on 5/31/16 at 11:34 a.m., Social Service Director (SSD) removed Resident # 33's roll from the plastic wrap with her bare hands. The SSD made a sandwich for the resident using the roll and barbeque meat. The SSD placed the sandwich on the resident's plate with her bare hands. During an observation on 5/31/16 at 12:07 p.m., The SSD grabbed Resident # 33's sandwich from her plate and placed it up to the resident's mouth. The resident took a bit of the sandwich and the SSD proceeded to take the sandwich from the resident's hand and placed it on her plate with her bare hands.		Performance improvement committee will review these audits and make recommendations on continuing these audits or decreasing the frequency of the audits. 5 Date of completion 7-7-2016 B 1. The social service Designee was educated on safe and sanitary handling of food when handling ready to eat food(s) employees must wear gloves . 2 No other residents identified. 3. All staff in-serviced on safe and sanitary handling of residents' food(s) when handling ready to eat food (s) employees must wear gloves. 4. DON/Designee/Dietary Manager will monitor meal service /tray set up in the main dining room for 3 meals daily for 5 days; then 2 meals daily for five days; than one meal daily for five days. The QAPI committee will review these audits and make recommendations gathered from these audits . 5 Date of completion 7-7-2016	

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	155778	A. BUILDING 00 B. WING	06/07/2016

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	During an interview on 6/6/16 at 9:56 a.m., The ADON (Assistant Director of Nursing) indicated staff should have worn gloves when handling resident's food. She further indicated staff should not have touched the resident's food with bare hands. A policy dated 11/12, identified as current, titled, "Glove Policy", provided by the ADON on 6/6/16 at 1:49 p.m., included but not limited to, "...Procedure: When handling ready to eat food all employees must wear gloves...." 3.1-21(i)(2)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;			

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	(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure proper infection control procedures during medication administration and blood glucose monitoring for 2 of 3 residents reviewed for infection control during insulin administration and glucose monitoring (Resident #56 and #59). Findings include: 1. On 6/2/16 at 12:06 p.m., LPN (Licensed Practical Nurse) #9 entered	F 0441	F441 It is the intent of this facility to ensure proper infection control procedures during medication administration and blood glucose monitoring. 1. LPN #9 was in-serviced on infection control procedures as it relates to wearing gloves when administering subcutaneous injections and washing hands after the removal of gloves. QMA #1 was in- serviced on not placing the glucometer in a potentially contaminated environment i.e. the pocket of her uniform. 2 No other residents identified. 3. Licensed nurses in-serviced on infection	07/07/2016

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	Resident #56's room, washed her hands, and administered a subcutaneous injection to Resident #56 without wearing gloves. LPN #9 left the room and did not perform hand sanitation after administering the injection. On 6/2/16 at 12:08 p.m., LPN #9 indicated she should have donned gloves before the medication injection and should have washed her hands after she gave the injection. On 6/2/16 at 12:25 p.m., the ADON (Assistant Director of Nursing) indicated staff should have worn gloves when injecting a medication and should have washed hands after the procedure. A policy titled, "MED-PASS, Subcutaneous Injections," dated March 2011 and identified as current by the ADON on 6/2/16 at 12:30 p.m., indicated, "...The Purpose of this procedure is to provide guidelines for the administration of medication by subcutaneous injection...Steps in the Procedure...2. Put on gloves...17. Perform hand antisepsis...." 2. On 6/2/16 at 10:51 a.m., QMA (Qualified Medication Aide) #1 entered Resident #59's room and performed a blood glucose test on Resident #59.		control procedures as it relates to wearing gloves to administer all subcutaneous injections and to wash hands after the removal of gloves. Licensed nurses and QMAs in-serviced on not placing the glucometer in a potentially contaminated environment i.e. the pocket of their uniform. 4. DON /Designee will monitor all licensed nurses for infection control during subcutaneous injections . i.e. wearing gloves during the injection and washing hands after removing the gloves once either by demonstration or mock demonstration. The DON/designee will monitor licensed nurses three times weekly for infection control practices during subcutaneous injections for wearing gloves during the injection and washing hands after removal of gloves. DON /Designee will observe all licensed nurses and QMAs during glucometer handling as it relates to not placing glucometer in potentially contaminated environment i.e. uniform pocket. 5 Date of completion 7-7-2016	

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	QMA #1 placed the soiled blood glucose meter in her uniform pocket and returned to the medication cart in the hallway. On 6/2/16 at 10:57 a.m., QMA #1 indicated the blood glucose meter should not have been placed in her uniform pocket and she should have cleaned the meter. On 6/2/16 at 11:16 a.m., LPN (Licensed Practical Nurse) #9 indicated QMA #1 should not have placed the soiled blood glucose meter into her pocket and should have cleaned the meter at the medication cart. A policy titled, "MED-PASS, Obtaining a Fingerstick Glucose Level," dated October 2011 and identified as current by the ADON (Assistant Director of Nursing) on 6/3/16 at 10:00 a.m., indicated, "...The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level...17. Clean and disinfect reusable equipment between uses...." 3.1-18(a) 3.1-18(l)			
F 0465	483.70(h)			

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SS=D Bldg. 00	SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure living environments were functional and comfortable for 4 of 30 resident rooms reviewed for comfortable living environments (Rooms #121, #124, #127 and #104). Findings include: On 6/7/16 at 11:19 a.m., during environmental rounds with the Maintenance Supervisor, the Housekeeping Supervisor, and the ADON (Assistant Director of Nursing) the following issues were observed: a. Room #121: The door to enter the room would not completely shut. The walls behind the heads of the two beds in the room were heavily marred and scuffed. A large gash was located above the baseboard next to the toilet in the bathroom. b. Room #124-A: The privacy curtain was observed to have a reddish-brown smear on it.	F 0465	F 465 It is the intent of the facility to ensure the living environments are functional and comfortable. 1. The door to room 121 was repaired to completely shut on 6-7-2016 the bathroom with a bent and jagged metal plate was repaired on 6-7-2016. The privacy curtain in room 124 was immediately laundered. The walls at the heads of the two beds in room # 121, 127 and room #104 which were scuffed and marred will be repaired on or before 7-7-2016 The large gash above the baseboard next to the toilet will be repaired on or before 7-7-2016 2 No other residents were affected 3. All staff were in serviced on filing a maintenance requisition on environmental defects will i.e. scoffed ,marred walls, privacy curtains dirty and potential hazardous defects. All maintenance requisitions will be given to the Administrator. 4 Administrator and Maintenance Director will visually audit each resident room for defects monthly. If repairs are needed the Administrator will prioritize repairs by writing an action plan The Administrator will give copies of these requisitions for repairs to the maintenance director with a completion date. Housekeeping supervisor will visual inspect all	07/07/2016

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	c. Room #127: The bathroom had a bent and jagged, metal plate next to the toilet. The bedroom walls had multiple scuffs by the two beds in the room. d. Room #104: The walls by the two beds in the room were heavily marred and scuffed. The Housekeeping Supervisor, on 6/7/16 at 11:30 a.m., indicated the privacy curtains in the rooms were scheduled to be cleaned on Fridays, but they were not cleaned the previous week. During an interview, on 6/7/16 11:45 a.m., the Maintenance Supervisor indicated he was busy remodeling a room in the facility and depended on the staff to let him know if other rooms needed attention by submitting a "Maintenance Work Request" form. The Maintenance Supervisor did not have completed forms or any maintenance logs for review. He indicated they were discarded when he completed the job requested. The Administrator, on 6/7/16 at 1:38 p.m., indicated the facility did not have a written maintenance policy but the facility was to be maintained in good repair. 3.1-19(f)		privacy curtains five times weekly and launder soiled privacy curtains and continue to launder privacy curtains weekly. The Quality Assurance Performance Improvement committee will review action plans maintenance requisitions and privacy curtain audits After the information is reviewed , the Q. A. committee will give recommendations regarding this information. 5. Date of completion 7-7-2016	