| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155187 | A. BUILDING 00<br>B. WING | 10/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00184049 and IN00184290.<br><br>This visit was done in conjunction with the Investigation of Complaint IN00185686.<br><br>Complaint IN00184049- Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00184290- Substantiated. Federal/State deficiencies related to the allegations are cited at F323.<br><br>Survey dates: October 26, 27, 28, 29 and 30, 2015.<br><br>Facility number: 000098<br>Provider number: 155187<br>AIM number: 100290980<br><br>Census bed type:<br>SNF/NF: 140<br>Total: 140<br><br>Census payor type:<br>Medicare: 13 | F 0000 | Submission of this Response and Plan of Corrections is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a plan of correction with ten (10) days of the survey as a condition of participation in the Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. | |

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

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| | Medicaid: 108<br>Other: 19<br>Total: 140<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed by 26143, on November 6, 2015. | | | |
| F 0242<br>SS=D<br>Bldg. 00 | 483.15(b)<br>SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br>Based on record review and interview the facility failed to ensure each resident had the choice to choose how many times a week they wished to take a shower for 1 of 3 residents reviewed for choices of the 4 residents who met the criteria for choices. (Resident #166)<br><br>Finding includes:<br><br>Interview with Resident #166 on | F 0242 | It is the intent of this facility to ensure that residents are able to make choices about aspects of his or her life in the facility that is significant to the resident.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**<br><br>Identified resident #166 was | 11/18/2015 |

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| | 10/26/2015 at 2:37 p.m., indicated she takes a shower two times a week. The resident further indicated she would like to take more than two showers a week.<br><br>The record for Resident #166 was reviewed on 10/28/2015 at 2:01 p.m. The resident was admitted to the facility on 11/15/13, her diagnoses included, but were not limited to, diabetes, dementia, and anxiety.<br><br>The Annual Minimum Data Set (MDS) assessment dated 9/23/15 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. The resident was totally dependent on staff assistance for bathing.<br><br>The Preference Worksheet dated 8/24/15 indicated the resident's number of showers desired weekly was everyday.<br><br>The current Preference Worksheet dated 10/28/15 indicated the resident's number of showers desired weekly was three days.<br><br>The Shower Schedule indicated the resident was to receive two showers a week on Wednesday and Saturday during the morning. | | interviewed for shower routine and preferences and preferred shower routine was implemented.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>Residents within the facility were interviewed for preferences. For residents unable to voice their own preferences, the legal guardians were interviewed.<br><br>Social Services and Unit Managers reviewed shower preferences and revised shower schedules. Residents within the facility have had Plan of Care revised to reflect shower preferences.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Upon admission/readmission to facility, quarterly as per MDS schedule, or as requested by resident/legal representative, Social Services will conduct a Resident Preference Interview.<br><br>Interview results are reviewed with the Nursing Unit Manager/Designee. Shower schedule is updated by the Unit Manager/Designee with preference | |

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| | Review of the completed October Shower Sheets indicated the resident had a shower on 10/3/15, 10/7/15, 10/10/15, 10/14/15, 10/17/15, 10/21/15, 10/24/15, and 10/28/15.<br><br>The current CNA Care Card indicated no information related to the resident's shower preference.<br><br>Interview with the Unit Manager on 10/29/15 at 9:24 a.m., indicated the resident had not been given showers according to her preference.<br><br>3.1-3(u)(3) | | changes for residents. Plans of Care are reviewed and updated quarterly and as needed with desired changes. Social Services/Designee will maintain the Resident Routine Preference Interviews.<br><br>Staff will be educated regarding Resident Preferences and the process to communicate preferences. Education to be completed by November 18, 2015.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Social Services/Designee will complete a Resident Preference Audit tool developed to include last date of interview and next due date of interview, not to exceed 90 days (quarterly).<br><br>Newly admitted residents will be added to the audit tool for monitoring. Results of the audits will be reported to the QAPI meeting monthly for tracking trends and satisfaction. Reporting will be trending for 6 months. This will be an ongoing process.<br>**Date systemic changes will be completed:** 11/18/2015 | |
| F 0246 SS=D Bldg. 00 | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES | | | |

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| | A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.<br>Based on observation, interview, and record review the facility failed to ensure the resident's physical environment helped maintain independent functioning by not keeping the resident's call light within reach for 1 of 40 residents observed for call lights within reach. (Resident #12)<br><br>Finding includes:<br><br>On 10/26/2015 at 11:46 a.m., Resident #12 was observed in his room seated in his wheelchair. The call light was observed wrapped tightly around his side rail which was in the down position, the call button was almost touching the floor. At that time, the resident was asked if he knew where his call light was located, he reached for the call button and was unable to reach it.<br><br>On 10/30/2015 at 11:12 a.m., during the environmental tour the resident was observed seated in his wheelchair, at the foot of his bed, and the call light was wrapped around his side rail, out of reach. | F 0246 | It is the intent of this facility to ensure the resident's physical environment helps maintain independent functioning by placing resident call lights within reach.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**<br><br>Resident #12 had the call light repositioned on the top of his bed where he could reach it.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>Residents have the potential to be affected by the alleged deficient practice. Staff will be educated on the placement of call lights within resident reach when in their rooms. Education to be completed by November 18, 2015.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** | 11/18/2015 |

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| | On 10/30/15 at 12:50 p.m., the resident was in his room. At that time, the call light was wrapped tightly around the resident's side rail and out of his reach. Interview with CNA #1 at that time, indicated the resident was alert and oriented and able to use his call light. She further indicated the resident preferred to have his call light on top of his bed so that he could reach it.<br><br>The record for Resident #12 was reviewed on 10/30/2015 at 11:54 a.m. The resident's diagnosis included, but were not limited to, heart failure, high blood pressure, stroke, non-Alzheimer dementia, hemiparesis, seizure disorder, and urgency of urination.<br><br>The Quarterly Minimum Data Set (MDS) assessment dated 8/26/15 indicated the resident's Brief Interview of Mental Status (BIMS) score was 14 indicating he was alert and oriented.<br><br>3.1-3(v)(1) | | Correct placement of call lights is audited daily with Guardian Angel rounds. Call light placement will be audited by management staff two additional times within 24 hours daily. Additional audits will be conducted daily for 4 weeks, 3 x weekly for 4 weeks, then weekly for 4 weeks. Angel Rounds is an ongoing process 5 x weekly.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Audit results for call light placement will be reported to the QAPI meeting monthly for 6 months, then continuing as QAPI team determines necessary.<br><br>**Date systemic changes will be completed:** 11/18/2015 | |
| F 0312 SS=D Bldg. 00 | 483.25(a)(3)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. | | | |

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| | Based on observation, record review and interview, the facility failed to ensure oral care was provided in a timely manner for 1 of 3 dependent residents reviewed for activities of daily living of the 60 residents who met the criteria for activities of daily living. (Resident #118)<br><br>Finding includes:<br><br>On 10/28/15 at 8:38 a.m., 10:15 a.m., 1:25 p.m., and 2:37 p.m., Resident #118 was observed in her room in bed. The resident's lips were dry and areas of dried saliva were observed in the corners of her mouth.<br><br>On 10/29/15 at 9:10 a.m., 1:33 p.m., and 2:36 p.m., the resident was again observed in her room in bed. The resident's lips were dry and there was dried saliva on her lips. At 4:30 p.m., LPN #1 entered the resident's room to administer her medications. The resident's lips were dry and cracked and she had thick saliva in the corners of her mouth and tongue. The LPN indicated at the time, the resident was in need of oral care.<br><br>The record for Resident #118 was reviewed on 10/28/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, dysphagia (difficulty | F 0312 | It is the intent of this facility to ensure that oral care is provided in a timely manner for its dependent residents<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**<br><br>Resident #118 received oral care. Resident did not have a negative outcome from alleged deficient practice.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>Dependent residents have the potential to be affected by the alleged deficient practice. Nursing staff will be re-educated on oral care. Education to be completed by November 18, 2015.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Director of Nursing Services/Designee will audit oral care of dependent residents 5 x weekly for 4 weeks, 3 x weekly for 4 weeks, and 2 x weekly for 4 weeks. Audits will be on varying shifts and | 11/18/2015 |

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| | swallowing) and hemiplegia (weakness).<br><br>The Quarterly Minimum Data Set (MDS) assessment dated 9/9/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 9, cognitive impairment. The MDS also indicated the resident required extensive assistance with personal hygiene.<br><br>The current 9/2015 plan of care indicated the resident was to have oral care provided daily and as needed.<br><br>Interview with the B Wing Unit Manager on 10/29/15 at 4:35 p.m., indicated the resident was dependent on staff for oral hygiene and the resident should have had oral hygiene in a more timely manner.<br><br>3.1-38(a)(3)(C) | | days of the week. Staff found in non-compliance will be re-educated. Continued con-compliance will result in the progressive disciplinary action per company guidelines.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Audit results for oral care will be reported in the QAPI meeting monthly for 6 months, then continuing as QAPI determines necessary.<br><br>**Date systemic changes will be completed:** 11/18/2015 | |
| F 0322 SS=D Bldg. 00 | 483.25(g)(2)<br>NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br>Based on the comprehensive assessment of a resident, the facility must ensure that --<br><br>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and | | | |

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| | (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.<br>Based on observation, record review and interview, the facility failed to ensure gastrostomy tube (a tube in the stomach) placement was checked prior to administering medications, as well as, ensuring the enteral tube feeding was started on time for 1 of 1 residents observed for gastrostomy tube medications. (Resident #118)<br><br>Finding includes:<br><br>On 10/29/15 at 2:36 p.m., Resident #118 was observed in her room in bed. The resident's gastrostomy tube feeding pump was not on at this time. At 4:20 p.m., LPN #1 entered the resident's room to administer medication. The LPN did not check for gastrostomy tube placement prior to flushing the resident's gastrostomy tube and administering the resident's medication. As the LPN entered the resident's room, the tube feeding pump was turned off.<br><br>Interview with the LPN at that time, indicated she should have checked for placement prior to giving the resident her | F 0322 | It is the intent of this facility to ensure that gastrostomy tube placement is checked prior to administering medications and that enteral tube feeding is started on time.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**<br><br>Resident #118 did not have a negative outcome from the alleged deficient practice.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>Residents with G-tubes have the potential to be affected by the alleged deficient practice. Licensed Nursing Staff have been re-educated on Golden Living protocol for G-tubes. Education to be completed by November 18, 2015.<br><br>**What measures will be put into place or what systemic changes will** | 11/18/2015 |

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| | medication. She also indicated she was not familiar with the resident and she would have to check and see what time the resident's tube feeding was to be started.<br><br>The record for Resident #118 was reviewed on 10/28/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, dysphagia (difficulty swallowing) and gastrostomy.<br><br>A Physician's Order dated 1/21/15 and on the current 10/2015 recap, indicated the resident was to receive Jevity 1.2, 65 milliliters (ml) per hour on at 2:00 p.m. and off at 7:00 a.m.<br><br>Interview with the B Wing Unit Manager on 10/29/15 at 4:30 p.m., indicated the LPN should have checked for placement prior to giving the medications. She also indicated the resident's tube feedings should have been started at 2:00 p.m.<br><br>The facility's current policy titled "Enteral Tube Medication Administration" provided by the Interim Director of Nursing was reviewed on 10/30/15 at 2:00 p.m. The policy indicated determine tube placement prior to giving medications. Verify correct placement of gastrostomy tube by placing a stethoscope on the resident's abdomen, | | **be made to ensure that the deficient practice does not recur:**<br><br>Director of Nursing Services/ Designee will observe administration of feeding/medications via G-tube 5x weekly, 3 x weekly, then weekly for 4 weeks. Licensed Nursing staff found to be out of compliance will be re-educated. Continued non-compliance will result in progressive disciplinary action per company guidelines.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Audit results for G-tube protocol will be reported to the QAPI meeting monthly for 6 months, and then continue as the QAPI team determines necessary.<br><br>**Date systemic changes will be completed:** 11/18/2015 | |

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| | inject 10-15 cubic centimeters (cc's) of air via the 60 cc syringe, listen for a "whooshing" sound, then slowly draw back gastric contents.<br><br>3.1-44(a)(2) | | | |
| F 0323<br>SS=D<br>Bldg. 00 | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>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.<br>Based on observation, record review, and interview, the facility failed to ensure residents received adequate supervision to prevent accidents related to keeping a close observation on residents with a history of falls for 2 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Residents #B and #C)<br><br>Findings include:<br><br>1. The closed record for Resident #B was reviewed on 10/28/15 at 4:15 p.m. The resident's diagnoses included, but were not limited to, psychosis, anxiety disorder, chronic pain, dementia, and history of falling.<br><br>The Admission Minimum Data Set | F 0323 | It is the intent of this facility to ensure residents receive adequate supervision to prevent accidents related to close observation of residents with a history of falls.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**<br><br>Resident #B no longer resides in the facility. Resident #C has been re-assessed for fall interventions with Physician orders and Nurse Aide Care Card. Interventions have been corrected and updated.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective** | 11/18/2015 |

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| | (MDS) assessment 6/18/15 indicated the resident had two or more falls since admission.<br><br>The Quarterly MDS assessment dated 9/6/15 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident needed extensive assist with one person physical assist with bed mobility, transfers, locomotion on and off unit, dressing, toilet use and personal hygiene. The resident had no falls since the prior assessment.<br><br>The current plan of care updated 9/2015 indicated the resident was at risk for falls related to impaired safety awareness and the use of Antianxiety medications. The Nursing approaches were to place the call light in reach, clip alarm, footwear to prevent slipping, and mat beside the bed.<br><br>An Incident investigation dated 7/17/15 at 5:01 a.m., provided by the Interim Director of Nursing was reviewed. The Incident indicated on 7/17/15 at 5:00 a.m., the resident was seated in his wheelchair and was brought out to the Nurse's station for closer observation. The resident stood up from the chair and fell before staff could assist him. The resident was observed with a laceration above his eyebrow and was sent to the | | **action(s) will be taken:**<br><br>Residents have the potential to be affected by this alleged deficient practice. Resident Fall Care Plans have been reviewed with Physician orders, Nurse Aide Care Cards along with visualization of the resident and their personal environment. Staff education on Plan of Care interventions and Nurse Aide Care Cards will be completed by November 18, 2015.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Director of Nursing Services/ Designee will audit resident fall interventions to ensure placement as care planned. Audits will be conducted 5 x weekly for 4 weeks, 3 x weekly for 4 weeks, then weekly for 4 weeks. Staff found to be non-compliant will be re-educated. Continued non-compliance will result in progressive disciplinary action per company guidelines.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Results of audits will be reported in the QAPI meeting monthly for 6 months, then continue as the QAPI | |

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| | 155187 | A. BUILDING 00<br>B. WING | 10/30/2015 |

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| | Emergency room for further treatment. The resident returned back to the facility on 7/17/15 with five sutures above his eyebrow.<br><br>The Incident follow up dated 7/22/15 indicated the resident's care plan indicated he was at risk for falls. It was recommended, when the resident was in his wheelchair he was to be seated at the Nurse's station for observation when possible due to his behaviors. A clip alarm would be added to his wheelchair.<br><br>Nursing Notes dated 8/11/15 at 8:17 p.m., indicated "Was called to resident room by CNA. When writer walked into room noticed that resident was on the floor next to his bed. Resident stated that he wanted to go to bed. Background: Resident has a history of confusion. Trying to self transfer himself when he wanted to go to bed. Resident is not able to make own decision related to diagnosis. While on the floor assessment was completed. No pain discomfort or deformities noted. Resident was able to crawl around on the floor per his moral. Called family to make aware and started neuro checks."<br><br>An Incident investigation dated 8/11/15 provided by the Interim Director of Nursing was reviewed. The Incident | | team determines necessary.<br><br>**Date systemic changes will be completed:** 11/18/2015 | |

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| | indicated the resident was found on the floor, alone in his room attempting to self transfer himself from his wheelchair to his bed.<br><br>Interview with the B Wing Unit Manager on 10/29/15 at 3:17 p.m., indicated the resident should not have been left alone in his room due to his behaviors and history of falling.<br><br>2. On 10/28/15 at 2:00 and 4:00 p.m., Resident #C was observed in bed. At those times, there was no bed alarm attached to the resident's bed.<br><br>On 10/29/15 at 10:20 a.m., and 1:50 p.m., the resident was observed in bed. At those times there was no bed alarm attached to the resident's bed.<br><br>Interview with CNA #2 on 10/20/15 at 1:55 p.m., indicated the CNA care card had no information regarding a bed alarm. She further indicated she was supposed to have a wheelchair alarm only.<br><br>Interview with LPN #2 on 10/29/15 at 1:57 p.m., indicated the resident refused the bed alarm so it was discontinued a long time ago. She further indicated the resident recently had a fall and she had thought both the bed and wheelchair | | | |

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| | alarms were put back into place as interventions.<br><br>The record for Resident #C was reviewed on 10/29/15 at 10:42 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, major depressive disorder severe with psychotic symptoms, psychosis, edema, embolism and thrombosis, heart failure, anxiety disorder, macular degeneration, history of falling, cataract, and Parkinson's disease.<br><br>The Quarterly Minimum Data Set (MDS) assessment dated 10/6/15 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident had one fall with minor injury since the last assessment.<br><br>Physician's Orders dated 10/20/15 indicated wheelchair alarm.<br><br>The current plan of care updated 10/2015 indicated the resident was at risk for falls related to new environment and history of falls. The Nursing Approach dated 2/17/15 indicated bed alarm.<br><br>Nursing Notes dated 10/19/15 6:00 p.m., indicated the writer was called to the resident's room and the resident was observed on the floor in the bathroom in | | | |

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| | a sitting position. The resident indicated she fell while going to the bathroom unassisted. The resident did not use the call light or ask for assistance. She sustained a skin tear to her hand.<br><br>Nursing Notes dated 10/20/15 at 10:05 a.m., indicated the Interdisciplinary Team (IDT) met to discuss the resident's recent fall. The resident feels she was able to transfer independently. The resident will have a sensor alarm in place to bed and wheelchair.<br><br>Interview with the D Wing Unit Manager on 10/29/15 at 3:05 p.m., indicated the current plan of care related to falls was for the resident to have a wheelchair sensor alarm to her chair. She further indicated she was unsure why the bed alarm was documented as being an intervention for the most recent fall.<br><br>This Federal Tag relates to Complaint IN00184290.<br><br>3.1-45(a)(2) | | | |
| F 0465<br>SS=E<br>Bldg. 00 | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. | | | |

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| | Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred bathroom walls, marred door frames, marred bathroom doors, missing vinyl floor tile, discolored bathroom floor tile, vinyl floor tile pulling away from the wall, marred heat/air registers, wood molding missing near closet, marred furniture and a privacy curtain stained in 4 of 4 wings throughout the facility. (Wings B, C, D, and E)<br><br>Findings include:<br><br>During The Environmental Tour on 10/30/15 at 11:45 a.m., with the Administrator, Maintenance Tech #1, and Maintenance Tech #2, and the Housekeeping Manager, the following was observed:<br><br>1. B Wing:<br><br>a. The bathroom wall was marred, the baseboard was loose next to the toilet, the heat/air register was marred, and the chairs arms/legs were scratched in room 101-1. Two residents resided in this room.<br><br>b. The bathroom walls, the bathroom door frame, and the heat/air register was marred in room 104-2. Two residents | F 0465 | It is the intent of this facility to ensure the resident's environment remains sanitary and comfortable related to resident room walls, doors, privacy curtains, floors, ceiling paint, and heaters.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**<br>Resident room walls were repaired/repainted for rooms 106, 109, 111, 116, 122, 129, 232, 313.<br>Resident bathrooms walls were repaired/repainted for rooms 101, 104, 106, 111, 116, 129, 215, 228, 233, 313.<br>Resident bathroom doors and trim were repainted for rooms 101, 104, 106, 111, 129, 215, 232, 233, 310, 313.<br>Resident room PTAC's were repainted for rooms 101, 104, 116, 232, 313.<br>Resident bathroom ceiling was repainted for room 106.<br>Resident side chairs were replaced in rooms 101, 111.<br>T.V. stand was replaced in room 111.<br>Resident bathroom baseboard was repaired/replaced for rooms 101, 228.<br>Resident room privacy curtain was cleaned for room 106.<br>Resident room window ledge was repaired for room 334.<br>Resident bathroom floor stains/damage were corrected for rooms 101, 311, 337. | 11/18/2015 |

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| | resided in this room.<br><br>c. The bedroom wall and privacy curtain were stained. The paint was cracked around the vent in the bathroom in room 106-1. Two residents resided in this room.<br><br>d. The wall at the head of bed was scratched/marred in room 109-1. Two residents resided in this room.<br><br>e. The bathroom door and walls were marred. The wall behind the head of the bed was marred. The television stand was scratched/marred. The arms and legs of the chair next to the bed were scratched in room 111-2. Two residents resided in this room.<br><br>f. The bathroom walls were marred, the head of the bead was marred, the heat/air register was marred in room 116-2. Two residents resided in this room.<br><br>g. The wall behind the head of the bed was scratched/marred in room 122-2. Two residents resided in this room.<br><br>h. The wood molding was missing near the closet in room 128-1. Two residents resided in this room.<br><br>i. The walls and baseboard in the | | Resident room molding near closet was replaced for room 128.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br>All residents have the potential to be affected by this alleged deficient practice. Facility had self identified these concerns in July and was working a plan to correct these . Plant operations staff have developed a schedule for repair/painting of resident rooms and resident bathrooms. Housekeeping staff and Guardian Angels were in-serviced on routine inspections of privacy curtains.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Plant operations will continue with resident room refurbishments. The Plant Operation Director/designee will review with the Executive Director/designee weekly, rooms to be scheduled for repair and painting. Any concerns of non-compliance will be corrected immediately; a repair order generated as necessary and the Executive Director/designee will be notified of plan to correct non compliance concerns. | |

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| | bedroom were marred, and the bathroom door was marred in room 129-2. Two residents resided in this room.<br><br>2. C Wing:<br><br>a. The bathroom door and door frame was marred in room 215-2. Two residents resided in this room.<br><br>b. The bathroom had missing baseboard in room 228-2. Two residents resided in this room.<br><br>c. The bathroom door was marred, the heat/air register was marred and had peeling paint, and the wood behind the bed was marred in room 232-2. Two residents resided is this room.<br><br>d. The bathroom walls were marred in room 233-1. Two residents resided in this room.<br><br>3. D Wing:<br><br>a. The wooden window ledge was separated from the drywall in room 334-2. Two residents resided in this room.<br><br>b. The bathroom floor tile was discolored in room 337-1. Two residents resided in | | | |

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| | this room.<br><br>E Wing:<br><br>a. The bathroom door was marred in room 310-2. Two residents resided in this room.<br><br>b. The bathroom had discolored floor tile, and the floor tile was pulled up at the entrance of the bathroom in room 311-1. Two residents resided in this room.<br><br>c. The bathroom walls were marred, and the bathroom door was marred inside and out, and the heat/air register in the room was marred in rooms 313-2 and 313-3. Three residents resided in this room.<br><br>Interview at that time with the Administrator, Housekeeping Manager, and the Maintenance Technicians, indicated all of the above areas were in need of cleaning and/or repair.<br><br>3.1-19(f) | | | |