:PARTMENT OF HEALTH AND HUMAN SERVICES
:NTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012
FORM APPROVED
RECEIVED OMB NO. 0938-0391

'EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	445125		C 06/07/2012

IE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IERICARE HEALTH AND REHABILITATION CENTER	3391 OLD GETWELL RD MEMPHIS, TN 38118

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: 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 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. This REQUIREMENT is not met as evidenced by: Intakes: TN00029853, TN00029865 Based on observations and interviews, it was determined the facility failed to accommodate the needs of residents by ensuring the call light was within the residents' reach and/or water was available for 8 of 17 Random Residents (RR) #3, 7, 9, 12, 13, 14, 15 and 16). The findings included: 1. Observations in RR #3's room on 6/6/12 at 8:23 AM, revealed the call light was laying on the floor, out of RR #3's reach. There was no water pitcher in the room. During an interview in RR #3's room on 6/6/12 at 8:30 AM, RR #3 stated, "...I wish I had some water... they [staff] don't bring water or ice..." 2. Observations in RR #7's room on 6/6/12 at 9:15 AM, revealed there was no water pitcher in the room. During an interview in RR #7's room on 6/6/12 at	F 246	F 246 The facility strives to accommodate the needs of residents by ensuring the call light is with-in reach of the resident and/or water is available for all residents except those whose medical condition would be endangered by having a water pitcher at the bedside. The residents involved in the deficient practice and all residents in the facility had water pitchers with water placed at their bedside and the call-light placed with-in reach of the resident. To prevent this deficient practice from recurring, the Supply Room Manager will check daily to assure that all resident's, except those with restrictions, have a water pitcher at their bedside. The nursing staff will pass water and ice at a minimum of two (2) times per	

Accepted POC 6/29/12 JP Phone

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert L Martham	Administrator	6/29/12

eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ıng the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ollowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ım participation.

This same POC was faxed 6/29/12 JP

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F 246	Continued From page 1 9:15 AM, RR #7 was asked if the staff pass ice or keep water in the water pitcher. RR #7 stated, "No." 3. Observations in RR #9's room on 6/6/12 at 9:19 AM, revealed the call light was laying on the floor, our of RR #9's reach. 4. Observations in RR #12's room on 6/6/12 at 9:37 AM, revealed the call light was tied to the bed rail behind the head of the mattress, out of RR #12's reach. 5. Observations in RR #13's room on 6/6/12 at 8:40 AM, revealed the call light was draped over the call light box, out of RR #13's reach. 6. Observations in RR #14's room on 6/6/12 at 9:05 AM, revealed the call light was laying on the floor, out of RR #14's reach. 7. Observations in RR #15's room on 6/6/12 at 1:50 PM, revealed the call light was draped over the call light box, out of RR #15's reach. 8. Observations in RR #16's room on 6/6/12 at 1:50 PM, revealed the call light was draped over the call light box, out of RR #16's reach. 9. During an interview in the family room on 6/7/12 at 10:30 AM, the Director of Nursing (DON) was asked, where a resident's call light should be kept. The DON stated, "Where the patient can use it..."	F 246	shift. The nursing staff will also assure that each resident's call light is with-in reach of the resident. The CNA team-leader for each unit will monitor each of their assigned units for compliance of call lights being with-in reach of the resident and/or availability of water for residents. The team leader(s) on each shift will submit the Daily Rounds Form to the charge nurse who will check for compliance. The charge nurse will submit the form to the Nursing Supervisor daily who will then check for compliance. Completion Date: July 6, 2012	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	F 280 The facility recognizes the importance	

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: 280	Continued From page 2 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to revise the comprehensive care plan for interventions to treat an existing pressure ulcer for 1 of 2 (Resident #1) sampled residents with a pressure ulcer. The findings included: Medical record review for Resident #1 documented an admission date of 12/16/11 with a readmission date of 5/25/12 with diagnoses of Right Tibia-Fibula Fracture, End Stage Renal Disease, Dialysis, Blind, Bipolar, Hypertension and Hypokalemia. Review of the "RESIDENT	F 280	of revising the care plan to reflect the necessary treatment and services needed to provide care to treat residents with pressure ulcers. The care plan of the resident affected by this deficient practice was immediately revised to reflect the current status of his pressure ulcer. To identify other residents who may be affected by this deficient practice, the care plans of all residents with wounds was revised by the Wound Care Specialist. To prevent this deficient practice from recurring the nurse initiating the treatment of a pressure ulcer will submit a copy of the physician's order to the treatment nurse and to the MDS/Care Plan Coordinator. The treatment nurse will then initiate the care plan for the pressure ulcer.	

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280	Continued From page 3 SKIN EVALUATION" documented if a score is above 8 then the resident is considered a high risk for skin breakdown. Resident #1's skin evaluation score dated 4/25/12 was "14" and the evaluation dated 6/4/12 was "15." Review of the "NURSES' ADMISSION ASSESSMENT" dated 5/25/12 documented, "...Indicate on diagram below all body marks such as... decubitus ulcers and other ulcerations or questionable markings considered other than normal... small open area [area circled on left upper posterior thigh]..." Review of a physician's order dated 5/25/12 documented, "Cleanse area to Lt [left] posterior thigh c [with] soap & [and] H2O [water], pat dry, then apply TAO [triple antibiotic ointment] q [every] day until resolved..." Review of the care plan dated 3/20/12 documented, "...Problem... POTENTIAL FOR PRESSURE ULCERS RELATED TO INCONTINENCE..." The care plan was not updated after the pressure ulcer was identified on 5/25/12. Review of the "WEEKLY PRESSURE ULCER HEALING RECORD" documented, "...DATE OF ONSET: 5-25-12... SITE/LOCATION: Left posterior thigh... DATE... 6/6/12... STAGE... [check mark] Stage 2... SIZE IN CM [centimeters] (LENGTH X [by] WIDTH)... 0.8 cm X 2.5 cm... DEPTH (cm)...0.1 cm..." Observations in Resident #1's room on 6/6/12 at 2:00 PM, revealed Resident #1 had an open area on his left upper posterior thigh approximately 1 cm X 2.5 cm.	F 280	The MDS/Care Plan will follow up weekly to assure that the pressure ulcer has been care planned and submit a copy of the Care Plan Monitoring Form to the DON who will randomly check for completion of the Care Plan. Completion Date: July 6, 2012	

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F 280	Continued From page 4 During an interview at the first floor Magoffin nurses' station on 6/6/12 at 2:20 PM, the treatment nurse confirmed the care plan had not been updated when the pressure ulcer was identified. During an interview in the family room on 6/7/12 at 10:30 AM, the Director of Nursing confirmed the care plan had not been updated when the pressure ulcer was identified.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on review of the "National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Prevention QUICK REFERENCE GUIDE," review of the resident skin evaluation memorandum, policy review, medical record review, observation and interview, it was determined the facility failed to treat a pressure ulcer for 1 of 2 (Resident #1) sampled residents with pressure ulcers. The findings included: Review of the "National Pressure Advisory Panel	F 314	F 314 The facility strives to ensure that residents having pressure ulcers receive treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. 11-7 nurse will check the TAR nightly to assure that all treatments have been documented.	

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314	Continued From page 5 (NPUAP) Pressure Ulcer Prevention QUICK REFERENCE GUIDE" documented, "...Skin Assessment... Educate professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration (hardness)... Inspect skin regularly for signs of redness in individuals identified as being at risk of pressure ulceration. The frequency of inspection may need to be increased in response to any deterioration in overall condition... Skin inspection should include assessment for localized heat, edema, or induration (hardness), especially in individuals with darkly pigmented skin... Document all skin assessments, noting details of any pain possibly related to pressure damage..." Review of the resident skin evaluation memorandum dated 4/5/12 documented, "Effective immediately, the schedule for completing the Resident Skin Evaluation has changed... An evaluation of the skin must also be included in the daily charting for the skilled residents and weekly charting for the ICF [intermediate care facility] residents. Charting should include turgor, skin temperature, continence, nutritional intake and whether resident has skin impairment with on-going treatment (...pressure ulcers, surgical wounds, rashes...)" Review of the facility's "Identifying Residents at Risk for Pressure Ulcers" policy documented, "...OBJECTIVE: Identify "at risk" patients needing prevention and the special factors placing them at risk. 1. RISK ASSESSMENT ...b. For at risk screen score of eight (8) or above, initiate pressure ulcer prevention plan of care... d.	F 314	The treatment nurse will check all treatment recerts for treatment orders. She will compare the present month TAR with the previous month's TAR to assure all treatment orders are transcribed to the new TAR. Completion Date: July 6, 2012	

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F 314	Continued From page 6 Include skin assessment in daily charting on SNF [skilled nursing facility] residents and in weekly charting on ICF residents. e. Identify the presence of the pressure sore. Include: site, odor, drainage and general appearance (color, characteristics). Medical record review for Resident #1 documented an admission date of 12/16/11 with a readmission date of 5/25/12 with diagnoses of Right Tibia-Fibula Fracture, End Stage Renal Disease, Dialysis, Blind, Bipolar, Hypertension and Hypokalemia. Review of the resident skin evaluation documented if a score is above 8 then the resident is considered a high risk for skin breakdown. Resident #1's skin evaluation score dated 4/25/12 was "14" and the skin evaluation dated 6/4/12 was "15"; indicating a high risk for skin breakdown. Review of the nurses' admission assessment dated 5/25/12 documented, "...Indicate on diagram below all body marks such as... decubitus ulcers and other ulcerations or questionable markings considered other than normal... small open area [area circled on left upper posterior thigh]..." Review of a physician's order dated 5/25/12 documented, "Cleanse area to Lt [left] posterior thigh c [with] soap & [and] H2O [water], pat dry, then apply TAO [triple antibiotic ointment] q [every] day until resolved..." Review of the Medication Administration Record (MAR) dated May 2012 documented, "Cleanse area to Lt posterior thigh c soap & H2O, pat dry, then apply TAO q day until resolved..." The treatment was not signed as being done for 5/25/12, 5/26/12, 5/27/12, 5/29/12, 5/30/12 and 5/31/12. Review of the MAR dated June 2012	F 314		

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F 314	Continued From page 7 revealed the treatment order was not transcribed from the May 2012 MAR to the June 2012 MAR. Review of the weekly pressure ulcer healing record documented, "...DATE OF ONSET: 5-25-12... SITE/LOCATION: Left posterior thigh... DATE... 6/6/12... STAGE...[check mark] Stage 2 ...SIZE IN CM [centimeters] (LENGTH X [by] WIDTH)... 0.8 cm X 2.5 cm... DEPTH (cm)... 0.1 cm..." Observations in Resident #1's room on 6/6/12 at 2:00 PM, revealed Resident #1 had an open area on his left upper posterior thigh approximately 1 cm X 2.5 cm. During an interview at the first floor Magoffin nurses' station on 6/6/12 at 2:20 PM, the treatment nurse was asked what the facility's protocol was when a pressure ulcer is discovered. The treatment nurse stated, "...the floor nurse initiates treatment and tells the treatment nurse... examine and treat it daily and document weekly..." The treatment nurse was asked if this protocol was followed for Resident #1. The treatment nurse stated, "No." The treatment nurse was asked if Resident #1 had been receiving treatment for the pressure ulcer on his left posterior thigh. The treatment nurse stated, "No." During an interview in the family room on 6/7/12 at 10:30 AM, the Director of Nursing (DON) was asked what the facility's protocol was when a pressure ulcer is discovered. The DON stated, "...once they [floor nurse] do the initial [assessment], it should be documented on the treatment nurse's weekly documentation form..."	F 314		

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: 314	Continued From page 8 The DON was asked if this was done for Resident #1. The DON stated, "...don't see it... no..." The DON was asked to review Resident #1's May and June 2012 MARs. The DON was asked how many days the treatment was done. The DON stated, "One." The DON was asked if the order for treatment of the pressure ulcer was transcribed to the June 2012 MAR. The DON stated, "No."	F 314		
: 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Intake number 29853 Based on observation and interview, it was determined the facility failed to ensure water was available for 1 of 4 (Resident #2) sampled residents and 6 of 17 (Random Residents (RR) #1, 2, 3, 4, 5 and 7) random residents observed during the initial tour of the facility. The findings included: 1. Observation in Resident #2's room on 6/6/12 at 8:10 AM, revealed there was no water pitcher in the room. 2. Observations in RR #1's room on 6/6/12 at 8:12 AM, revealed there was no water pitcher in the room.	F 327	F 327 The facility strives to accommodate the needs of residents by ensuring the call light is with-in reach of the resident and/or water is available for all residents except those whose medical condition would be endangered by having a water pitcher at the bedside. The residents involved in the deficient practice and all residents in the facility had water pitchers with water placed at their bedside and the call-light placed with-in reach of the resident. To prevent this deficient practice from recurring, the Supply Room Manager will check daily to assure that all	

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F 327	Continued From page 9 3. Observations in RR #2's room on 6/6/12 at 8:15 AM, revealed there was no water pitcher in the room. 4. Observations in RR #3's room on 6/6/12 at 8:23 AM, revealed there was no water pitcher in the room. During an interview in RR #3's room on 6/6/12 at 8:30 AM, RR #3 stated, "...I wish I had some water... they [staff] don't bring water or ice..." 5. Observations in RR #4's room on 6/6/12 at 8:30 AM, revealed there was no water pitcher in the room. 6. Observations in RR #5's room on 6/6/12 at 8:37 AM, revealed there was no water pitcher in the room. 7. Observations in RR #7's room on 6/6/12 at 9:15 AM, revealed there was no water pitcher in the room. During an interview in RR #7's room on 6/6/12 at 9:15 AM, RR #7 was asked if the staff pass ice or keep water in the water pitcher. RR #7 stated, "No." 8. During an interview in the family room on 6/7/12 at 10:30 AM, the Director of Nursing (DON) was asked if the residents should have water pitchers in their rooms. The DON stated, "They should." The DON confirmed there was no water pitcher in Rooms 514 and 517.	F 327	resident's, except those with restrictions, have a water pitcher at their bedside. The nursing staff will pass water and ice at a minimum of two (2) times per shift. The nursing staff will also assure that each resident's call light is with-in reach of the resident. The CNA team-leader for each unit will monitor each of their assigned units for compliance of call lights being with-in reach of the resident and/or availability of water for residents. The team leader(s) on each shift will submit the Daily Rounds Form to the charge nurse who will check for compliance. The charge nurse will submit the form to the Nursing Supervisor daily who will then check for compliance.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463	Completion Date: July 6, 2012 An in-house communication system,	

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' 463	Continued From page 10 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure the resident call system was functional for 2 of 4 (Residents #1 and 2) sampled residents and 4 of 17 (Random Resident (RR) #6, 7, 8 and 11) random residents observed during the initial tour. The findings included: 1. Review of the facility's "ENVIRONMENT SAFETY POLICY" documented, "[company name] strives to provide a safe and healthful working/learning environment for all residents and staff and visitors. Environment supervisor is responsible for providing a working environment free from recognized health and safety hazards." 2. Observations in room 120 on 6/6/12 at 1:30 PM, revealed Resident #1's call light was not functioning. During an interview in Room 120 on 6/6/12 at 1:30 PM, Resident #1 was asked if he had told staff about his call light not working. Resident #1 stated, "...yes, they won't do anything about it..." 3. Observations in room 508 on 6/6/12 at 2:00 PM, revealed Resident #2's call light was not functioning.	F 463	connecting residents rooms, and toilet/ bathing facilities to the nurse's station is critical to the total care of the resident. On June 27, 2012, a communications systems company was on site to check each individual call unit in each room/ each bed. The check included both visual and audio components. Those not functioning properly were marked for repair and/or replacement. The six (6) residents, adversely affected by this deficient practice, were included in the system check, covering all nursing units in the facility. Until any malfunctioning unit is repaired/replaced, the resident will use a hand bell, and be checked by the nursing staff every hour until the defective call light has been repaired and/or replaced. Those units which were not working properly, during the facility-wide check, have	

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F 463	Continued From page 11 4. Observations in room 120 on 6/6/12 at 1:30 PM, revealed RR #6's call light was not functioning. 5. Observations in room 417 on 6/6/12 at 1:40 PM, revealed RR #7's call light was not functioning. During an interview in room 417 on 6/6/12 at 1:40 PM, RR #7 was asked if he had told staff about his call light not working. RR #7 stated, "...it never works... they won't do anything about it..." 6. Observations in room 416 on 6/6/12 at 1:45 PM, revealed RR #8's call light was not functioning. 7. Observations in Room 414 on 6/6/12 at 1:50 PM, revealed RR #11's call light was not functioning. 8. During an interview in the family room on 6/7/12 at 10:30 AM, the Director of Nursing (DON) was asked what the facility's protocol is when call lights are nonfunctioning. The DON stated, "...we report it to maintenance... check every 2 hours [routine resident check]... if not working [call lights] increase to every hour..."The DON was asked if the facility was doing this for any residents. The DON stated, "No... no one has reported it to me..." During an interview in the first floor McRee hallway on 6/7/12 at 11:23 AM, the Environmental Services Director (ESD) was asked how often he checked the physical environment of the facility. The ESD stated, "...on a daily basis... when you	F 463	received a hand bell. Malfunctioning units will continue to be noted in the Unit Maintenance Log, on each nursing station. Maintenance staff will check the Log each morning and makes arrangements to repair the item, and note time, date, and staff initials regarding the repair process. Completion Date: July 6, 2012	

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	445125		C 06/07/2012

IE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 12 get busy and get called away... it [daily checks] doesn't always happen..."	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure the environment was clean and sanitary in 4 of 4 (First Floor Magoffin, Second Floor Magoffin, Second Floor McRee and First Floor McRee) halls in the facility. The findings included: 1. Review of the facility's "ENVIRONMENT SAFETY POLICY" documented, "[company name] strives to provide a safe and healthful working/learning environment for all residents and staff and visitors. Environment supervisor is responsible for providing a working environment free from recognized health and safety hazards." 2. Observations on the first floor Magoffin hallway on 6/6/12 at 9:15 AM, revealed the following: a. Room 115: toilet tissue on floor in bathroom, dirty toilet seat and strong urine smell. b. Hallway: two loose wire molds with screws exposed on each side of an exit door.	F 465	F 465 The facility will offer, to all residents, their families, staff members, and visitors, a sanitary, safe, and comfortable environment. The findings will be addressed and corrected for all members of the community, who are affected by the facility's deficient practices of proper environmental safety and sanitation, Both Nursing and Housekeeping will share in these responsibilities. A daily housekeeping check list is completed for the 7AM-3PM shift and filed with the Environmental Services Manager. This check list will be expanded to include more detailed areas as noted in the survey findings. The expanded check list will require housekeeping staff to utilize the Unit Maintenance	

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F 465	Continued From page 13 3. Observations on the second floor Magoffin hallway on 6/6/12 at 9:00 AM, revealed the following: a. Room 208: overbed table on window side of room was dirty and on which was multiple empty and partially filled cups and two sandwiches with a wrapper labeled "HS [hour of sleep]" snack. b. Room 210: rolled up blanket in front of room door. 5. Observations on the second floor McRee hallway on 6/6/12 at 8:10 AM revealed the following: a. Room 504: paint peeling from the wall by the closet b. Room 508: paint and wall chipped away by light switch, paint bubbled up and peeling off in the closet with paint chips on the floor and a pipe under the resident's sink with a significant leak and a large plastic tote under the pipe with standing water in the tote. c. Room 511: clothes piled in floor of both closets spilling out onto the floor in the room. d. Room 514: exposed pipe with the insulation around it tearing apart. e. Hallway: floor tile missing by the day room and a partial chipped floor tile missing in front of soiled utility room. 4. Observations on the first floor McRee hallway on 6/6/12 beginning at 9:27 AM, revealed the following: a. Room 408: pipe under resident's sink with a significant leak. b. Hallway: 2 empty soda cans on the floor across hall from the clean linen room and several pieces of paper on the floor in front of the nurses' station. c. Nurses' station: telephone jack hanging out of	F 465	Log to request review and/or repair of specific safety hazards observed during their cleaning routine. The Environmental Manager or his designee will check the Maintenance Log two or three times during the shift and make a final check before he (Manager) leaves his shift. Competition Date: July 6, 2012	

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F 465	Continued From page 14 the wall. d. The light in the clean linen room did not work and individual latex gloves, heel boots, a hair brush, plastic wrappers, toilet tissue and an open bottle of skin lotion were laying on the floor in the corner of the clean linen room. During an interview in room 408 on 6/6/12 at 9:27 AM, Resident #4 was asked if he told any staff about the pipe under his sink leaking. Resident #4 stated, "Yes, they just ignore it... they were putting a plastic garbage bag over it so no one would use it..." During an interview in the clean linen room on first floor McRee on 6/7/12 at 10:15 AM, the Assistant Administrator was asked if the supplies and trash laying on floor in the corner of the clean linen room was acceptable. The Assistant Administrator stated, "No... this shouldn't be here..." 5. During an interview in the first floor McRee nurses' station on 6/7/12 at 10:05 AM, the Assistant Administrator was asked who was responsible for the maintenance of the physical environment of the facility. The Assistant Administrator stated, "...[named the Environmental Services Director]..." During an interview in the first floor McRee hallway on 6/7/12 at 11:23 AM, the Environmental Services Director (ESD) was asked how often he checked the physical environment of the facility. The ESD stated, "...on a daily basis... when you get busy and get called away... it [daily checks] doesn't always happen..."	F 465		
F 468	483.70(h)(3) CORRIDORS HAVE FIRMLY	F 468	F 468 Any form of ambulation requires a	

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: 468 SS=D	Continued From page 15 SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure the handrails were firmly secured and safe as evidenced by missing and loose handrails on 2 of 4 (First Floor McRee and Second Floor McRee) halls in the facility. The findings included: 1. Review of the facility's "ENVIRONMENT SAFETY POLICY" documented, "[company name] strives to provide a safe and healthful working/learning environment for all residents and staff and visitors. Environment supervisor is responsible for providing a working environment free from recognized health and safety hazards." 2. Observations in the first floor McRee hallway by room 421 on 6/6/12 at 3:25 PM, revealed a loose handrail with a cap for the bolt missing. Observations in the first floor McRee hallway by the storage room on 6/6/12 at 3:28 PM, revealed loose handrails on both sides of the hallway. Observations in the first floor McRee hallway across from room 416 on 6/6/12 at 3:30 PM, revealed a missing hand rail with the braces sticking out from the wall.	F 468	safe sense of stability, especially residents with an unsteady gait. The most obvious support is a firmly secured handrail, through-out the facility. Handrails on the two (2) nursing units affected by the facilities deficiency in providing secure handrails have been repaired. To assure the safety of this feature for all residents, a member of the maintenance staff will complete a visual walk-around of all handrails daily, while checking each nursing unit's maintenance log. Any faulty handrail section will be repaired immediately, to avoid injury to any resident. Completion Date: July 6, 2012	

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F 468	Continued From page 16 Observations in the first floor McRee hallway by the time clock on 6/6/12 at 3:35 PM, revealed a missing hand rail with the braces stick out from the wall. 3. Observations in the second floor McRee hallway by room 524 on 6/6/12 at 3:20 PM, revealed a missing rounded corner handrail. 4. During an interview in the first floor McRee nurses' station on 6/7/12 at 10:05 AM, the Assistant Administrator was asked who was responsible for the maintenance of the physical environment of the facility. The Assistant Administrator stated, "...[named the Environmental Services Director]..." During an interview in the first floor McRee hallway on 6/7/12 at 11:23 AM, the Environmental Services Director (ESD) was asked how often he checked the physical environment of the facility. The ESD stated, "...on a daily basis... when you get busy and get called away... it [daily checks] doesn't always happen..."	F 468		