DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055331	A. BUILDING _____ B. WING _____	C 03/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP	1601 5TH AVENUE SAN RAFAEL, CA 94901

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the Abbreviated Survey investigation of linked complaints: CA00362133 and CA00368576. Representing the California Department of Public Health: 31594, Health Facilities Evaluator Nurse (HFEN) The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.	F 000	**San Rafael Healthcare and Wellness Center submits this response and the plan of correction as a part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be constructed as an admission of any alleged deficiency cited or liability. The provider submits this plan of correctionwith the intention that it is inadmissible by any third party in civil criminal action or proceedings against the provider or it employees, agents, officers, directors, or shareholders. The providers reserve the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the government agency or third party.**	
F 223 SS=D	DEFICIENCIES WERE ISSUED FOR COMPLAINT CA00362133 and CA00368576 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect one resident (Resident 1) from another resident (Resident 3) with known behaviors and lack of impulse control. This failure caused pain and distress, with the potential for greater harm to a pre-existing neck injury.	F 223		

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

Asst Admin 4/11/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Spoke c Lindsay Arglade

Received by Kristin Monroe on 5/1/14 Kr @ 11:32 a.m.

#13

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F 223	Continued From page 1 During an interview on 7/24/13 at 3:45 p.m., Resident 1 stated that Resident 3 hit her with a pillow (thrown out his window), as she sat outside. Resident 1 stated that, "I just had neck surgery a few months ago; that is why I have my neck brace on now." Resident 1 stated that Resident 3, "thinks he can bully me." During an interview on 8/8/13 at 10:58 a.m., Random Resident 4 stated that Resident 3, "is not easy to live with." Random Resident 4 overheard the assault, but could not see it because Resident 3's privacy curtain was pulled. During an interview at 11:07 a.m., Resident 3 stated he did not recall the incident. Resident 1 stated, at 11:17 a.m., that her neck was fine, but that Resident 3 had hit her with intent, "as hard as he could. He was angry. It hurt. I wouldn't say that if it was just a throw." Resident 1 stated that two weeks after the incident, Resident 3 called her names as she walked by. During an interview on 9/9/13 at 3 p.m., Maintenance Staff A stated that Resident 3 had taken a shovel to one of the screens in his room in the past. Maintenance Staff A did not know where Resident 3 got the shovel, but said he reported to the facility administrator that Resident 3 could hurt someone. Maintenance Staff A also stated that during a staff meeting the administrator told staff to, "keep an eye," on Resident 3. A record review on 9/9/13 at 3:25 p.m., indicated that Resident 3 had severe cognitive impairment and a history of behaviors for which Resident 3	F 223	F Tag 223 1. Resident 1 and 3 have been discharged from the facility Resident 1 was discharged on 10/12/13 to Eureka with family Resident 2 was discharged on 11/01/13 to a SNF in Medicino County The Interdisciplinary Team has done a visual facility round on 3/24/14 and no other resident have been found to be affected 2. Upon admission, the admitting nurse will assess the resident. The nurse will utilize the History and Physical, nursing notes and medication list to ascertain if behavioral risks are present Those residents determined to have potential for behavioral risks will be referred for psychiatric evaluation and recommendation IDT will work on a discharge plan for residents who have psychiatric behaviors to a psychiatric facility	

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F 223	Continued From page 2 received behavior modification medication daily. Some of the behaviors noted in the Nursing Progress Notes included: 3/27/13, "[Resident 3] very agitated, threw his dinner to the floor and wanted to go out his bedroom window. Police were called." 7/13/13, "[Resident 3] stressed by loud music coming from [Resident 1's] radio so he threw his pillow hitting Resident 1's neck;" 7/14/13, [Resident 3] threw his walker at his roommate and then walked outside and threw his walker in the middle of the street;" 7/15/13, [Resident 3] had a verbal outburst." The facility response included medication adjustments from the psychiatrist and primary physician, and an order on 7/16/13, for nursing to monitor behaviors by using hash marks. A review of Resident 1's record at 4:10 p.m., indicated that Resident 1 was alert and oriented, independent, and responsible for herself. Resident 1 listened to music and would go outside to smoke. A Nursing Progress Note, dated 7/13/13 at 8 p.m., indicated that Resident 1 was, upset and very agitated because around 7:25 p.m., she was hit by a pillow and was crying, shouting, and telling everyone to call the police.	F 223	The facility will assign appropriate staff to ensure monitoring of residents who have the potential to have behavioral issues present 3. A care conference will be held within the first 7 days of admission and IDT will discuss interventions to manage identified residents with psychiatric/behavioral disturbances. Possible triggers for behavioral issues will be discussed. A comprehensive plan of care will be developed to address their particular issues. This information will be given to charge nurses, C.N.A staff as well as managers in the form of in-services/trainings so identified residents with known behavioral or impulse control issues can be monitored.	4/11/14
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by:	F 240		

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F 240	Continued From page 3 Based on observation, interview, and record review, the facility failed to provide a clean and inviting environment for 1 of 2 sampled residents (Resident 2). This failure caused Resident 2 to feel isolated, angry, and ignored, when the facility did the following: 1. Admitted Resident 2 to a dirty, cold, and un maintained room; 2. A water spill was not cleaned up timely and left as a fall hazard, until the following morning; 3. Request for a Kleenex was denied for the reason that none were available and; 4. A floor vent blew cold air on Resident 2 and a blanket was placed over it to block the flow, but created a potential fall hazard. Findings: During an observation on 8/8/13 at 11:50 a.m., Resident 2 pointed to a folded blanket that was lying on the floor next to her bed, between the sliding glass doors and her bed. The blanket covered a vent which blew out cold air. The bedroom floor had peeling and broken linoleum, and a discolored bathroom door frame with remains of what appeared to be old glue to which rubber molding was at one time attached. A hand grip in the bathroom, to the right of the toilet, was affixed to an unpainted, and rough piece of wood, with splinters. A towel rack or hand grip was wound with black masking tape. The garbage can in the bathroom had a broken foot pedal. The toilet paper was difficult to access because of its location on the wall and the proximity of an elevated toilet seat. The soap dispenser had chipped and pealing paint beneath it, from where it had been remounted. The molding where the wall met the floor had missing areas. Black areas, that looked like dirt, were in all the corners and areas where linoleum were broken. The walls in	F 240	**Those residents at risk for harming others will be placed on 15 minute checks to ensure their whereabouts and divert from other residents when displaying behavioral issues** **Other services will be utilized as needed such as referral to pain management, psychologist referral for counseling or MD referral to r/o possible infection that may be affecting their behavior** **4. DON/ designee will monitor daily the status of residents that have been identified as potential for harming other residents. If identified an immediate risk, the physician and ancillary staff will be notified to re-evaluate or adjust the plan of care** **If the resident is unable to be managed within the facility, alternate placement options will be explored by the social services department**	4/11/14

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F 240	Continued From page 4 both the bathroom and bedroom had stains and peeling paint. The screen on the sliding glass door was torn and there was dirt in the tracks. Behind Resident 2's bed was a white patched area that had not been sanded down and then repainted to match the walls. During a concurrent interview at 11:50 a.m., Resident 2 became teary and her voice broke as she described arriving the night before when she was admitted from an acute care hospital. Resident 2 stated she was dying and was angry and depressed by the environment she had been admitted to saying the facility was, "like being in a slum place." She stated that she felt homesick and isolated and became upset by the environment. Resident 2 stated that when she accidentally spilled some ice chips at her bedside, staff ignored it and left it to melt into a puddle on the floor. The following morning, when Resident 2 pointed out the wet puddle by her bed, staff offered Resident 2 skid socks, rather than clean it up. When asked for a Kleenex, staff told her they did not have anymore and came back with a wad of toilet paper. The room had no television and staff told Resident 2 that the facility was not responsible for supplying televisions. When the floor vent began to blow cold air during the night, staff brought a folded blanket and placed it over the vent. Resident 2 stated she remained cold. A record review indicated Resident 2 was admitted from an acute care hospital on 8/7/13 at 10 p.m. The record indicated Resident 2 had no cognitive impediments and was the responsible party for health care. During an interview on 8/8/13 at 12:26 p.m.,	F 240	**Process will be reviewed monthly during CQI/QAA for up to 12 months and as needed** **F 240** **1. The Subject Room for Resident # 2 that had a blanket that covered the vent which blew out cold air was removed on 4/11/14** **The Subject Room for Resident # 2 that had a bedroom floor peeling and broken linoleum and had a discolored bathroom door frame with remains of what appeared to be old glue to which rubber molding was at one time attached was fixed on 3/20/14 during facility remodel** **The Subject room for Resident # 2 which had a hand grip in the bathroom to the right of the toilet was fixed on 3/20/14 during facility remodel** **The Subject room for Resident # 2 which had a broken foot pedal on the garbage can in the bathroom was replaced on 4/11/14**	

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F 240	Continued From page 5 Housekeeping Staff B stated that Resident 2's bedroom may not have been cleaned before admission because it had been an empty room, and housekeeping worked until 3 p.m. Housekeeping Staff B said it was maintenance's job to fix broken wastebaskets and equipment. Housekeeping Staff B stated it was housekeeping job to wipe down walls and clean the sliding doors once a month. Housekeeping B said nursing staff should follow up with spills that occurred during the night. During an interview on 9/9/13 at 2:30 p.m., Maintenance Staff A stated that staff had been told not to cover floor air vents with blankets, and that the facility intended to renovate and that was why he did not paint over patchwork. A review of Maintenance A's logs indicated that Resident 2's room was not listed as a concern for maintenance. During an observation at 2:51, the supply closets did not have Kleenex. When asked, Administrative Staff E stated that Kleenex was usually stocked in the supply closet and that the facility had a central supply downstairs. During an observation and interview at 2:52 p.m., Random Resident 7 stated, "This place is a dump - electrical is bad." An observation of Resident 7's room revealed that the floor vent was covered with a rug. When stepped on, the rug dipped into a hole causing an uneven floor. When the rug was pulled back, the vent grids were bent and created a depressed area. Random Resident 7 stated that the staff kept the vent covered because of cold air that came out. During an interview on 9/10/13 at 1:50 p.m.,	F 240	**The subject room for Resident # 2 that had a molding wall, missing floor area, peeling paint and a missing screen on the glass door was fixed on 3/20/14 during facility remodel** **2. All Residents have the potential of being affected by this deficient practice** **Maintenance Director did a full facility round and checked all 26 resident room and all vents will be replaced by 4/11/14** **Maintenance Director did a full facility tour and each resident's bedroom environment there** **was found no other broken linoleum** **All staff members in the facility will be in-serviced on how to report all facility uncleanliness, hazardous conditions and faulty equipment to charge nurse and write them in the maintenance log binder that is located at the nurse's station**	

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F 240	Continued From page 6 Unlicensed Staff D stated the facility had not been kept clean since new ownership in 2012, "not enough supplies," and complaints from residents about the temperature, "so we just put thick blankets over the vents." A review of housekeeping manager's duties, "Daily Work Routine - Account Manager," from Healthcare Services Group, Inc., indicated that it was their job to: "Inspect for problems/odors throughout facility during although. Ensure all Deep Cleans start on time without fail...QCI's/Inspect Complete Room Cleaning, Ensure Housekeepers are continuing with routines...." During a job description review on 9/12/13, "Director of Environmental Services," Section 4.4, page 1 of 6, indicated the following: "Ensures a safe.....environment for residents, staff, and visitors in accordance with Federal, State and Corporate requirements." Review of the California Health and Safety Code Section 1599.1, pg. 11, "Written policies; rights of patients and facility obligations", indicated that, (e) The facility shall be clean, sanitary, and in good repair at all times."	F 240	3. Upon notice of admission the admission coordinator will notify in writing the Housekeeping Department and C.N.A staff to clean and prepare room for arrival of new resident. This will include cleaning of bedside table and over bed table as well as making beds and reporting any faulty equipment. Maintenance will ensure that lights are working properly and bed control is functioning. Maintenance supervisor will do daily rounds of rooms to ensure equipment is in working order no safety hazards are present and room temperature is comfortable. Maintenance supervisor will provide ongoing maintenance of rooms including repainting as needed. Housekeeping staff will provide deep cleaning of rooms and floor as well as washing the walls and cleaning sliding doors once a month. Central Supply personnel will fully stock all necessary supplies up to 2 times a day to ensure that all needs of residents are met throughout the day	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253		

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F 253	Continued From page 7 Based on observation, interview, and record review, the facility failed to maintain a safe, comfortable, and sanitary physical environment for two sampled residents (Resident 1 and Resident 2) and two random residents (Resident 4, Resident 5) when: 1) A window screen was not replaced in a timely manner, and Resident 1 was hit by a pillow thrown out the bedroom window. This failure caused pain, with the potential for further damage to a prior neck injury; 2) One resident's (Resident 2) bedroom environment had broken linoleum, dirty walls, unpainted fixtures, and a ventilation system which blew cold air out and that staff covered with a blanket. This failure had the potential of causing injury, when items placed on the floor (blanket) created a tripping hazard; repaired and unfinished functional was equipment which was left unpainted could cause splinters; and the room also had items wrapped with tape, left unfinished, and with broken surfaces, which potentially could not be adequately cleaned. This failure also resulted in Resident 2 feeling depressed by the unpleasant environment and angry to be placed in a dirty room. Findings: 1) During an interview on 7/24/13 at 3:45 p.m., Resident 1 stated that Resident 3 hit her with a pillow, thrown through his bedroom window. Resident 3 hit Resident 2 as she sat outside beneath his window, listening to music through headsets: "...as hard as he could. He was angry. It hurt." Resident 1 stated that Resident 3 hit her with force, upon her head. Resident 1 had a neck brace on from a previous injury. During an environmental observation on 8/8/13 at	F 253	**4. Social services/designee will interview the resident on the day of admission or within 2 days regarding the comfort and cleanliness of the room. Any issues will be forwarded to the appropriate departments for review and correction.** **Housekeeping and Maintenance departments will report directly to the administrator regarding the status of resident rooms weekly.** **Administrator will report to CQI/QAA findings of room status reports for further review and correction.**	

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F 253	Continued From page 8 10:58 a.m., Resident 3's bedroom window, above his bed, had no screen and was open. The smell of cigarette smoke wafted from the outdoors to the inside. An interview with Resident 3's roommate disclosed that the screen had been removed by Resident 3 and had not been replaced by maintenance. During an interview on 8/8/13 at 11:40 a.m., Maintenance Staff A stated he had replaced Resident 3's bathroom screen, but did not know about the bedroom screen. Maintenance Staff A said he walked around the facility's perimeter every day and checked the exterior facility for maintenance needs, but admitted he had not seen Resident 3's missing bedroom screen. A review of the maintenance log indicated that the bedroom screen had not been identified as missing or replaced. 2) During an observation on 8/8/13 at 11:50 a.m., Resident 2 pointed to a folded blanket and lying on the floor next to her bed, between the sliding glass doors and her bed. The blanket covered a vent which blew out cold air. The bedroom floor had peeling and broken linoleum, a discolored bathroom door frame with remains of what appeared to be old glue. A hand grip in the bathroom, to the right of the toilet, was affixed to an unpainted, and rough piece of wood, with splinters. A towel rack or hand grip was wound with black masking tape. The garbage can in the bathroom had a broken foot pedal. The toilet paper was difficult to access because of its location on the wall and the proximity of an elevated toilet seat. The soap dispenser had chipped and pealing paint beneath it, from where it had been remounted. The molding where the wall met the floor had missing areas. Black	F 253	253 1. **Window screens in subject resident rooms 1, 2, 3, and 4 was fixed on 12/10/13** **Subject resident's #2 bedrooms environment that had a broken linoleum has been replaced during facility remodel on 4/11/14. Subject resident's #2 that had dirty walls have been cleaned on 4/11/14. Subject resident's #2 bedroom that had un-painted fixtures, and a blanket on the ventilation system that blew cold air was removed and fixed on 4/9/14** **Room # 8 that smelled of urine, has been cleaned and no longer has the urine smell** **Room # 8 that had a stain on the wall in the room has been cleaned on 4/1/14** **Room # 8 that had a bathroom door that did not stay close, was fixed on 4/1/14** **Room #18 that had an unpainted area where the paper towel dispenser was mounted was re-painted during facility remodel on 4/11/14**	

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F 253	Continued From page 9 areas, that looked like dirt, were in all the corners and areas where linoleum were broken. The walls in both the bathroom and bedroom had stains and peeling paint. The screen on the sliding glass door was torn and there was dirt in the tracks. Behind Resident 2's bed was a white patched area that had not been sanded down and then repainted to match the walls. The general impression of the room was old and tired, dirty and depressing. During a concurrent interview at 11:50 a.m., Resident 2 became teary and her voice broke as she described arriving the night before from an acute care hospital. Resident 2 stated she was dying and was angry and depressed by the environment she had been admitted to. Resident 2 stated that she felt homesick and isolated and became upset by the environment. During an interview on 8/8/13 at 12:26 p.m., Housekeeping Staff B stated that Resident 2's bedroom may not have been cleaned before admission because it had been an empty room, and housekeeping worked until 3 p.m. Housekeeping Staff B said it was maintenance's job to fix broken wastebaskets and equipment. Housekeeping Staff B stated it was housekeeping job to wipe down walls and clean the sliding doors once a month. When walked thru random rules and pointed out stained walls, and areas around floor that appeared dirty, Housekeeping Staff B stated she did not think it was dirty. During an interview at 12:40 p.m. , Random Resident 4 stated that he had observed housekeeping clean his wall once since admission. A record review indicated Resident 4 had lived in the facility multiple months.	F 253	**Room # 18 that had a sticky floor when walked upon was fixed during remodeling of facility on 4/1/14** **Room # 18 that had an un-patched screw holes in the wall between closet and bathroom door have been fixed on 3/31/14** **Room #25 where there had been peeling paint behind beds A and B were repainted on 3/28/14** **Room # 25 where the overhead light over bed A that did not work was replaced with a new light fixture on 3/31/14** **Room # 25 where the corner of the roomnear the bathroom,** **that had white patches against the yellow paint and the base molding which was sloppily painted white with overspill onto the wall was painted and new molding was done on 3/31/14** **Hall 1 which had a large stain in the carpet outside the supply closet has been replaced by vinyl flooring on 3/28/14** **The enclosed patio on the west of building that had multiple equipment stored there, have been removed on 4/7/14**	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055331	A. BUILDING _____ B. WING _____	C 03/14/2014

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F 253	Continued From page 10 An observation of the hallway wall outside Bedroom #2, revealed a sticky and dark substance. When asked, Licensed Staff C stated, "it may be a booger." During observation and interview on 9/9/13 at 1:30 p.m., photographs taken of Resident 2's room confirmed previous observations. Further observations of the facility revealed the following: A. Room #8 smelled of urine and had a stained wall along the interior side of the wall bisecting the bedroom from the hallway. The bathroom door did not stay closed. The floor between the bathroom and bedroom was stained and sticky to walk upon. The toilet basin had stains. A food tray rested on the floor of the bedroom in BC. A partially filled urinal hung off the foot of bed 8B. When asked, Random Resident 6 stated that the room, "could be kept a lot cleaner than it is," and that there was a constant smell of urine. B. Room #18 bathroom had a white, unpainted area where the paper towel dispenser had been remounted, and the wall was never finished to match its surroundings. The floor was sticky when walked upon, and there were un-patched screw holes in the wall between the closet and the bathroom door. Random Resident 5 stated that it took housekeeping a little time before getting to cleaning, "a little dust in the corner here and a web over there." C. Room #25 had peeling paint behind beds A and B. The overhead light over bed A did not work. A spider web was in the right corner of the room near the bathroom. The bathroom had white patches against the yellow paint and the base molding had been sloppily painted white with overspill onto the wall. D. Hall 1 had a large stain in the carpet outside	F 253	**2. Maintenance Director did a full facility round and checked all 16 window screens and non needed to be replaced.** **Maintenance Director did a full facility tour and each resident's bedroom environment there was found no other broken linoleum** **All staff members in the facility will be in-serviced on how to report all facility uncleanliness, hazardous conditions and faulty equipment to charge nurse and write them in the maintenance log binder that is located at the nurse's station** **3. Daily facility rounds will be Performed by facility maintenance director or designee with housekeeping staff on how to ensure that all deep cleaning schedule is kept and starts on time without fail.** **Facility Residents Ambassadors Which include all department**	4/11/14

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F 253	Continued From page 11 the supply closet. E. An enclosed patio on the west of building, had multiple equipment stored there. Seven bedrooms accessed the patio through sliding glass doors. Maintenance Staff A explained that a red line painted down the length of the floor meant that equipment could be stored to the left against the rails, and the right was to be available for residents to walk. The right side had one Hoyer lift, two forward walkers, two wheelchairs, one empty oxygen tank, and one full oxygen tank, secured to a wheelchair which blocked resident traffic. F. Room #1's sliding screen was not in its track and leaned upright over the opening. The door opened to an east patio which rooms #1, 2, 5, 8, 9, 10, and 11 had access to. The patio was cluttered with 11 wheelchairs, one Hoyer lift, seven bath transfer chairs, five walkers, four small tables, one trash can, an activity cart and a housekeeping cart. There was a red line down the center, but items were stacked on both sides. A door to the activity room was open and the screen was retracted into the hall, unused. During an interview on 9/9/13 at 2:30 p.m., Maintenance Staff A stated that staff had been told not to cover floor air vents with blankets, and that the facility intended to renovate and that was why he did not paint over patchwork. During an interview on 9/10/13 at 1:50 p.m., Unlicensed Staff D stated the facility had not been kept clean since new ownership in 2012. A review of housekeeping manager's duties, "Daily Work Routine - Account Manager," from Healthcare Services Group, Inc., indicated that it was their job to: "Inspect for problems/odors	F 253	**Head members such as: Dietary Manager, Housekeeping Manager, Assistant Administrator, Social Service Director, Accounts PayableManager, MDS coordinator, Main-tenance Director, Admissions Coor-dinator, Medical Records Personnel, and Activity Director, will also perform facility rounds daily to ensure that residents roomsare maintained in a sanitary, orderlyand comfortable interior.** **New Account Manager for Healthcare Service Group, Inc has reviewed job duties with staff on 4/8/14** **4. Results of these will be given to the administrator for review. Any concerns will be brought to the CQI/QAA Meetings for further follow up as needed.**	

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F 253	Continued From page 12 throughout facility during walk through. Ensure all Deep Cleans start on time without fail...QCI's/Inspect Complete Room Cleaning, Ensure Housekeepers are continuing with routines...." During a job description review on 9/12/13, "Director of Environmental Services," Section 4.4, page 1 of 6, indicated the following: "Ensures a safe.....environment for residents, staff and visitors in accordance with Federal, State and Corporate requirements." A review of a Certified Nursing Assistant (CNA) job description, indicated the following under "General Duties and Responsibilities:" Perform all duties as assigned and in accordance with facility's established policies and procedures, nursing care procedures, safety rules and regulations...Make beds, clean bedside and over-bed tables.....Report all hazardous conditions and faulty equipment to the Charge Nurse immediately."	F 253	BLANK	