STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145135	A. BUILDING _____ B. WING _____	03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURGIN MANOR	**900 EAST SCOTT OLNEY, IL 62450**

(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 Annual Certification Survey Complaint 1651018\IL83607 -- no deficiencies	F 000		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer	F 203		

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

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F 203	Continued From page 1 or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide written notification of transfer and reasons for the move for 1 of 1 residents (R24) reviewed for transfer and/or involuntary discharge in the sample of 24. The findings include: 1. R24's medical record documented: R24 was originally admitted to the facility on 11/20/15 with diagnoses including: Dementia, Chronic pain, Anxiety, Unspecified Schizophrenia, Mental Disorder. R24's Social History dated 11/23/15 stated R24's family considers R24's placement in the facility to be permanent. Nursing Notes from 2/19/16 at noon document that R24 was transferred to another facility by Burgin Manor staff.	F 203		

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F 203	Continued From page 2 Social Service notes dated 2/3/16 indicate,.. Spoke with E26 (Registered Nurse, RN), Z4 (Power Of Attorney-POA) and Z5 (Family). Resident has been very combative since his return from an out of State behavioral unit.....During our meeting family was made aware that Burgin Manor is not appropriate for resident and resident is not appropriate for this facility. We are unable to meet his needs. Advised family that I would research and find a possible facility that could provide him the care he needs. A care plan dated 2/19/16 (the date of transfer) states the resident plans to be discharged to another facility but does not indicate the reason for the transfer. There was no documentation for review that the facility provided R24's family or POA with any written notice of the facility's plans to discharge R24. E9 (Social Services) stated on 2/25/16 at 1:38pm that R24's family was in agreement with the move and she felt if they were okay with it that no notice would be necessary. E1 (Administrator) stated on 2/25/16 at 12:55pm that the facility has not had any involuntary discharge issues in the past year.	F 203		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, interview and	F 241		

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F 241	Continued From page 3	F 241		

observation the facility failed to provide timely assistance for 4 of 24 residents (R4, R8, R10, and R17) reviewed for call light response in the sample of 24 and 2 residents (R26 and R27) in the supplemental sample.

Findings include:

1. On 02-23-2016 at 9:05 AM, R8 stated that on 02-22-2016 on the night shift he turned his call light on at 10:30 PM because he was hungry. R8 stated that the staff did not come to his room until 2:30 AM.

2. On 02-23-2016 at 9:35 AM, R26's call light was observed to be on for 15 minutes before E21 (Certified Nurses Aide, CNA) came into R26's room. R26 stated that she has to wait many times for her call light to be answered and usually it's because she has to go to the bathroom. R26 stated that waiting that long makes her very uncomfortable and she's afraid she might have an accident.

3. On 02/24/16 at 10 AM, R10 stated she has waited 30 minutes for her light to be answered.

4. On 02/24/16 at 10 AM, R 27 stated she has waited 45 minutes for her light to be answered and she has been incontinent of urine due to the long wait.

5. Resident Council Meeting Minutes from 01/12/16 document a complaint regarding the amount of time it takes for the staff to answer call lights.

6. Resident Council Meeting Minutes from 7/6/15 document the following: 'Residents feel that when

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F 241	Continued From page 4 CNAs call in that it makes it hard on everyone and residents aren't getting adequate care and call lights answered.' 7. On 02/23/16 from 10:31AM to 10:51AM, R17's call light was observed on and not answered. On 2/25/16 at 10:00 AM R17 stated she sometimes has accidents waiting for her light to be answered. 8. On 02-23-2016 at 12:30 PM, R4 stated that when he turns the call light on it takes a long time sometimes. R4 stated it takes over 20 minutes sometimes for anyone to come to his room. 9. On 02/23/16 at 11:00AM, Z2 (Family) stated she was visiting a family member earlier today. Z2 stated while visiting earlier this morning, the roommate pushed the call light and it took 40 minutes before someone answered. 10. During an interview with Z1 (Family) on 02/22/16 at 4:00 PM she stated staff often do not respond to call lights for as long as thirty minutes. Z1 said residents have incontinent episodes because staff do not respond quickly enough to call lights. Z1 said she visits weekly and staff are observed to respond to call lights slowly at least twice a month.	F 241		
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 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	F 280		

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F 280	Continued From page 5 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 interview and record review, the facility failed to identify interventions and parameters related to comfort care for 2 of 24 residents (R7 and R9) reviewed for comfort care orders in the sample of 24. Findings Include: 1. R9's Physician's Order, dated 5/14/14, documents 'Comfort Measures Only, No Feeding Tubes, No IVs (Intravenous), No Hospitalization.' The undated Policy and Procedures for Comfort Care/ Hospice Care provided by E2 (Director of Nursing) on 2/24/16 documents: The physician will review the resident's decision making abilities and help the staff obtain maximum resident participation in the care plan.' and 'The physician will ..... help address symptoms to enhance comfort and minimize pain.' R9's Long Term Care Plan documents Comfort Measures, No IVs, No Hospital, No Feeding Tube and Approach: Provide comfort measures: assist to position of	F 280		

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F 280	Continued From page 6 comfort with pillows; offer soft lighting; decrease noise, offer back rub, lotion to skin. On 02/24/16 at 12:58 PM, E9 (Social Service Director) stated Comfort Care means no extreme measures. She went on to say she has not talked to the family regarding comfort care, but she does know the family does want antibiotics. On 2/23/16 at 11:45AM, E12 (Speech Therapist) stated when questioned regarding RE9's diet, liquids, and choking that I do not work with residents on comfort care. There is no documentation of a meeting with the physician, family, and staff regarding comfort measures for R9. The Policy for Comfort Care/ Hospice does not include treatment or services not offered to residents on Comfort Care 2. The Physician Order Sheet dated 2/1/16 - 2/29/16, documents R7 was readmitted to the facility on 2/1/16 with diagnosis of, Lymphocytic Leukemia/B Cell type, . On 2/22/16 at 11:00AM, E26 (Registered Nurse/Unit Director), states that R7 is now on Comfort Care because R7 has a form of Leukemia and family is not pursing any more treatment. On 02/22/16, a review of R7's current Care Plan dated 2/01/16 shows no specific interventions for Comfort Care.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement the plan of care for six of twenty four residents (R9, R11, R14, R18 , R19, and R20) reviewed for following Physician Orders in the sample of 24. Findings include: 1. A Physician Order from The Dialysis Center, dated 02/12/16 notes R11 is to receive 1 scoop of protein powder mixed into food with every meal. During a meal observation on 02/23/16 at approximately 12:00 PM, R11 did not receive a scoop of protein powder with the meal. The diet card was observed during the noon meal and it did not identify that R11 was to receive protein powder with meals. During an interview with E25 (Dietitian) on 02/25/16 at 1:10 PM, she stated since the diet order came from The Dialysis Center staff did not see the order so it was not implemented until today. 2. The February, 2016 Physician's Orders documents an order for R14 with a start date of 03/18/11 stating R14 is to have her left leg and foot elevated above the chest while lying down and an order dated 10/14/15 for built-up foamed handles for utensils at all meals. R14 was observed lying in bed on 02/22/16 at 10:10AM and 3:00PM and on 02/23/16 at 11:30AM and 4:05PM without her left leg elevated. On 02/23/16 at the noon meal R14 was observed eating without foam handled utensils.	F 282		

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F 282	Continued From page 8 3. The February, 2016 Physician's Orders documents an order for R19 with a start date of 12/26/13 for a Personal Safety Alarm (PSA) on at all times related to safety awareness deficiency. On 02/25/16 at 10:30AM, R19 was observed in a recliner in his room. The PSA was observed sitting on the bedside table unattached to an alarm. E32 (Registered Nurse) stated on 02/25/16 at 1:15PM, R19 is up for a review to discontinue the alarms, but the current order is for the alarm to be on at all times. 4. R9's Physician Orders, dated 2/1/16 through 2/29/16, document the use of Nosey Cups and a Wedge Cushion. At 1:00PM, on 2/22/16 and 2/23/16, R9 was noted sitting on a pommel cushion not a wedge cushion. During noon meal on 2/22/16 and 2/23/19, R9 was not drinking out of a Nosey Cup. On 2/23/16 at 3:30 PM, E26 (Registered Nurse), stated R9 does not use a Nosey Cup. She went on to say she is unsure why R9 has a pommel instead of a wedge cushion. 5. R20's Physician Orders, dated 2/1/16 through 2/29/16, document an order for Raised Foot Pedals to the Wheelchair for Left Extremity Edema. On 2/24/16 at 3PM the foot pedals of R20's wheelchair was not elevated as she sat at the nurses station. On 2/25/16 at 12:00 Noon R20 was noted at a table in the dining room sleeping with her feet on the floor. 6. The Physician Order Sheet for R18 dated 2/01/16 - 2/29/16 contains the following order; PSA, (Personal Safety Alarm), in chair and bed related to fall risk.R18's Long Term care plan, last	F 282		

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F 282	Continued From page 9 reviewed on 2/10/16, reads, Fall Risk: High. Ensure pressure alarm is in place and functioning. Ensure clip alarm is fastened and string is short enough to sound with resident movements. On 2/25/16, at 10:15 AM, R18 was seated in a personal recliner that had a pressure alarm present in the seat that was not functioning because the cord was detached from the alarm unit. R18's pressure alarm cord remained detached from 10:15 AM through the time that staff came to assist R18 to ambulate with a walker, gait belt, and assistance to the dining room for lunch, at 11:05 AM.	F 282		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to properly store and date oxygen and nebulizer supplies for 2 of 5 residents (R6, R8) reviewed for respiratory supplies in the sample of 24. and 3 residents (R30, R34, R35) in the supplemental sample.	F 328		

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F 328	Continued From page 10 Findings include: 1. On 02/22/16 at 9:50AM, oxygen tubing was observed hanging on R6's oxygen concentrator in the resident's room. The tubing was not observed to be protected from contamination. At this time, R6's nebulizer mouth piece was observed unprotected sitting on the bedside table. 2. On 02/22/16 at 10:10AM, the cannula end of oxygen tubing was observed lying on the floor in R30's room. The tubing was attached to an oxygen concentrator. At this time, E23 (Licensed Practical Nurse-LPN) was observed to pick up the tubing. 3. On 02/22/16 at 10:35AM, oxygen tubing was observed attached to an oxygen concentrator in R34's room. The cannula end of the tubing was observed lying inside a trash can. At this time, E10 (Certified Nurse Aide-CNA) was observed to pick up the tubing and place it on the concentrator. The tubing was not dated. On 02/22/16 at 1:55PM, the same concentrator was observed in R34's room with oxygen tubing in a plastic bag hanging on the concentrator with no date. 4. On 02/22/16 at 10:40AM, an uncovered nebulizer mask was observed sitting on R35's bedside table. The tubing on the nebulizer was dated 02/06/16. 5. On 02-23-2016 at 8:30 AM, R8's Hand Held Nebulizer and tubing were lying on the floor. The Facility's 02/29/10 Policy and Procedure-Changing Oxygen Tubing and	F 328		

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F 328	Continued From page 11 Nebulizer Sets states, "1. Oxygen tubing and nebulizer sets will be changed weekly by the 11-7 nurse. Date tubing with clear IV (intravenous) tape"..... 2. Nebulizer set should be stored in cloth bag when not in use." "Also please change the cloth bags of oxygen concentrators and liquid station every week. Anytime tubing is not in use it should be stored in cloth bag."	F 328		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 12 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to properly label and store medications, keep the medication cart locked while unattended, assure the proper staff had access to the medication room and assure the medication refrigerator was at the proper temperature. This has the potential to affect all 117 residents living in the facility. Findings include: The Facility's Resident Census and Conditions of Residents dated 02/22/16 stated there are 117 residents in the facility. 1. On 02/23/16 at 9:45AM, the Suites Medication Room was observed to have a drawer with Nystatin Powder and Orajel stored together belonging to R30. 2. On 02/23/16 at 4:15PM, a medication cup containing a green pill cut in half and one light red gel capsule was observed sitting on the bedside table in R25's room. R25 stated these are her medications and she will take them. R25 also stated the nurse just gave them to her a little bit ago. On 02/24/16 at 9:00AM, E3 (Assistant Director of Nurses) stated R25 is not care	F 431		

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F 431	Continued From page 13	F 431		

planned for self administration of medications and the medications should not have been left at the bedside.

3. On 02/23/16 at 5:15PM, the East-Center Medication Cart was observed to be unlocked with no facility staff in site. At this time, this surveyor went to E2 (Director of Nurses) and E3 who stated the cart is to be locked if unattended by a nurse.

4. The Facility's undated Policy and Procedures for Storage of Drugs and Biologicals states, "All drugs and biologicals must be stored in locked compartments under proper temperature controls, and only authorized personnel are to have access to the keys.....The cart must be locked when the nurse does not have it within visual control."

On 02/24/16 at 10:30AM, E3 stated the Orajel and Nystatin Powder should not be stored in the same drawer.

5. On 2/25/16 at 10:30 AM there was a gray and red capsule in a medication cup in the top drawer of the Aspen medication cart, the cup was not labeled . E28 (Registered Nurse) stated she had poured a Keflex up early for R36.

6. On 2/26/16 at 11:00 AM the medication refrigerator temperature on the Aspen Unit was 50 degrees.

7. On 2/26/16 at 11:00 AM, in the Aspen Unit medication room, there were (8) 12 ounce cans of carbonated beverage in the medication refrigerator. E28 (Registered Nures) stated at that time that E30 (Certified Nurse Aide, CNA) put

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F 431	Continued From page 14 them in the refrigerator. E30 stated when questioned that E28 gave her the keys to the medication room to put the beverages in the refrigerator this morning. The Facility's Policy and Procedures for Storage of Drugs and Biologicals (undated) documents only authorized personnel are to have access to the keys to the medication room. 8. On 2/26/16 at 10:20 AM there was a wicker basket in the Aspen Medication Room containing residents topical medications. In the basket was a tube of pain relieving cream with no resident name label.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 15 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to handle soiled linens appropriately to prevent cross contamination. This has the potential to affect all 117 residents living in the facility. Finding include: The Facility's Resident Census and Conditions of Residents form, dated 02/22/16 documented the facility had a census of 117 residents 1. At 11:00 AM on 02/25/16 a soiled bed sheet and comforter were laying on an over bed table in R21's room. There was no barrier between the linens and the over bed table. (One resident occupied this room.) E12 (Speech Therapist) was in the room at this time . E12 said R21 had	F 441		

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an infection in a wound on her buttocks. E12 said contact isolation procedures were to be followed when caring for R21. Soiled Linen Containers in R21 's room are labeled bio hazardous.

2. On 02/22/16 at 10:35AM, E10 (Certified Nurse Aide-CNA) was observed removing dirty linens from R34's bed. E10 held the dirty linens up against her body as she departed the room.

3. On 02/23/16 at 9:40AM, the Suites Medication Cart was observed to have toe nail and finger nail clippers lying in the top right drawer inside a box of insulin needles. At this time, E27 (Registered Nurse-RN) stated she uses these items to trim resident's nails and cleans the items with vinegar and water before putting them back in the cart.

4. On 02/23/16 at 11:00AM, E24 (Certified Nurse Aide-CNA) was observed performing catheter care on R5. E24 was observed placing wash cloths in a shared bathroom sink to wet them for the catheter care. After performing the care, E24 was observed pulling up R5's covers with the contaminated gloves used to perform the catheter care. E24 then removed her gloves and bagged the dirty linens and left the room. E24 did not wash her hands before leaving the room.

5. On 02/24/16 at 10:46AM, the East-East Medication Cart was observed to have a can of thickener inside a drawer. Inside the can was a medication cup. At this time, E3 (Assistant Director of Nurses) stated this should not be inside the container. E3 also stated toe nail and finger nail clippers are to be cleaned with disinfecting wipes as per the label directions.

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F 441	Continued From page 17 6. On 02/24/16 at 1:00PM, a pillow was observed sitting on the floor in the Suites Clean Linen closet. 7. Observation in the Suites shower room on 2/23/16 at 10:00 am found clean towels stored on a shower seat unprotected from contamination. 8. Observation in the Aspen soiled utility room at 10:45 am found several brown stained and soiled wash cloths floating in the hopper. 9. On 02/22/16 at 11:55 AM, a pile of soiled linens were in R15's bathroom floor. When E22 (Certified Nurses Aide) was asked about the linens being in the floor, she stated she should have put the linens in a plastic bag. 10. On 2/25/16 at 11:00 AM in the Aspen Medication Room resident snacks were being stored in a bowl beside the medication sink. Dry liquid splashes were noted on the bags of chips and the packages of cookies.	F 441		
F 465 SS=F	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 observation, record review and interview, the facility failed to provide a clean, comfortable and well maintained environment for	F 465		

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residents, staff and visitors during the survey. This has the potential to affect all 117 residents in the facility.

The findings include:

The facility's Resident Census and Conditions of Residents form, dated, 2/22/16 documented the facility had a census of 117 residents.

1. On 2/23/16 at 9:15am in the East Dining room 10 drop down table extenders were very soiled with dried food debris.

2. On 2/23/16 at 9:30am in the medical records room a blanket was taped over the Air Conditioning unit to keep out a draft.

3. On 2/23/16 at 10:15am in the Suites dining room a blue chair by the television was stained and food debris was noted under the cushion.

4. On 2/23/16 at 10:20am the far West wall in the hall to the Suites dining room was scraped and discolored at wheel chair height.

5. On 2/23/16 at 10:40am in the Aspen shower room the second shower stall shower head was leaking and the shower chair safety belt was noted to be covered with a pink and black material. The trash can was filled and trash had spilled to the floor.

6. On 2/23/16 at 10:45am in the Aspen small sitting room the brown recliner was soiled. The wall behind the television was scraped and the coved mop board was pulling away from the wall behind the television.

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F 465	Continued From page 19 7. On 2/23/16 at 10:50am in the Aspen work room the cabinet with eye glasses and denture cups was soiled with food debris. 8. On 2/23/16 at 10:55am in the Aspen hall, the wall grate under the cow mural was very soiled. 9. On 2/23/16 at 11:00am in the Aspen dining room the refrigerator was noted to have a broken thermometer and the unit was very soiled. 10. On 2/23/16 at 11:00am the four brown recliners in the Aspen dining area were very soiled . 11.On 02/22/16 at 10:15AM, wet towels were observed at the base of the toilet in the shared bathroom between Rooms 176 and 178. A hand written note was taped to the wall above the toilet instructing staff not to remove the towels because the toilet over flows. At this time, E23 (Licensed Practical Nurse) flushed the toilet and forceful water sprayed up out the toilet onto the floor. E23 stated she was not aware this was happening. 12. On 02/23/16 at 9:45AM, the following was observed in the Suites Medication Room: *a six drawer plastic tower containing medical supplies was dusty and dirty with a dried brown substance noted *the top of a two drawer plastic tower sitting on the floor was observed to be dusty *a plastic container sitting on the counter was observed to have dried brown residue in scattered areas on the outside 13. On 02/23/16 at 10:00AM, the following was observed: *A sit-to stand mechanical lift was observed sitting near the East-Center Nursing Station. The	F 465		

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F 465	Continued From page 20 lift was in need of cleaning. *R37's wheel chair was observed to be torn on the back rest at the top corners. 14. On 02/23/16 at 4:20PM a sit-to-stand mechanical lift was observed sitting in Room 142 on the East-East Hall. The lift was in need of cleaning. Both arm rests and one leg rest was torn and tattered. The foot base was dirty with particles of dust and bebri and a round light brown circular discolored object resembling a pill was observed. At this time, E1 (Administrator) and E29 (Registered Nurse) each agreed it looked like a pill. 15. On 2/25/16 at 11:00 AM the covering of R31 and R20's wheelchair arm bolsters was noted to be tattered with holes revealing the foam. . Observations of the bathing areas for the Suites, East Center and Aspen unit found personal care items to be unlabeled, soiled and stored commingled with other toiletries or on the floor. 16. On 2/23/16 at 10:00am in the Suites bathing room 2 cabinets were observed where bathing supplies were stored. The cabinets contained soiled (visible hairs) hair brushes and combs without identifying labels. A bar of used soap was without an identifying name label. An unlabeled used stick deodorant was also among the other resident care supplies. 17. On 2/23/16 at 10:40am in the Aspen unit bathing room a supply cabinet held a soiled comb and brush without an identifying label. Unlabeled and previously used stick deodorant was also observed in the cabinet. A second unlabeled, soiled comb was observed on the hand wash sink	F 465		

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F 465	Continued From page 21 behind the faucets. Numerous cardboard boxes of personal supplies were stored on the floor at the back of the shower room. There was no means available to keep the boxes off the floor for effective floor cleaning and to protect the boxes from contamination. 18. On 2/23/16 at approximately 12:15pm in the East Center shower room an unlabeled stick deodorant was noted.	F 465		