STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 STANDARD SURVEY: 4/25/19 CENSUS: 131 SAMPLE SIZE: 26 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of the medical record, it was determined that the facility failed to consistently provide feeding assistance for two residents who were assessed as needing assistance with feeding. This deficient practice was identified for Residents #10 and #88, 2 of 26 reviewed for "Activities of Daily Living (ADLs)" and was evidenced by the following: 1. According to the Admission Record (AR), Resident #10 was admitted to the facility on [redacted], with diagnoses that included: [redacted] The quarterly Minimum Data Set (MDS) dated	F 677	1. Per St's evaluation, resident #10's goals have been met. Resident is able to feed self. For resident #88, the Unit Manager immediately corrected the practice and assisted the resident. Both resident #10 and resident #88 were safe and in stable condition. 2. Any resident requiring assistance with feeding has the potential to be affected by this practice. 3. The DON provided education and in-service on 4/22/2019 to staff that serve meals and provide feeding assistance to dependent residents. The education and in-service included tray set-up, use of adaptive equipment and Center's Policy	5/15/19

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

Electronically Signed | 05/10/2019

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F 677	Continued From page 1 [redacted], reflected Resident #10 had a Brief Interview for Mental Status of [redacted], indicating the Resident's cognition was [redacted] The MDS further indicated the resident required assistance with Activities of Daily Living (ADLs) and setup for meals. During an initial tour of the facility on 4/16/19 at 10:19 AM, the surveyor observed Resident #10 lying in bed with a breakfast tray on the bedside table. The surveyor noted the resident's breakfast was served on a divided plate and also noted [redacted] and [redacted] on the tray. There was no staff member in the room. During an interview on 4/16/19 at 10:30 AM, Resident #10 stated staff did not help him/her with feeding and added; "I feed myself." On 4/22/18 at 7:45 AM, the surveyor observed Resident #10 eating by his/her self and no staff present to assist. When interviewed on 4/22/19 at 8:00 AM, in the presence of the Licensed Practical Nurse (LPN), Resident #10 stated "No one helps me, I feed myself." During an interview with the Director of Rehabilitation (DOR) on 4/22/19 at 9:00 a.m., the DOR stated "someone should be there while the Resident is eating. The Resident (Resident #10) lacks range of motion in the [redacted]." During an interview with the Speech Therapist (ST) on 4/22/19 at 12:00 PM, the ST stated; "the resident is at risk for [redacted] due to (his/her) [redacted] and [redacted]."	F 677	on Assistance with Meals. The DON and Unit Manager observed the residents that required feeding assistance during meal times between 4/22/2019 to 4/26/2019. No deficient practice identified. The DOR, Dietitian and unit manager will meet 2X a week for 4 weeks to review the feeding assistance for resident #10. The use of the adaptive equipment during meal time was reviewed by the DOR and dietitian 2X a week for 4 weeks and update care plan. Feeding assistance and adaptive equipment was added on the meal ticket. Personalized plan of care was updated. 4. The DOR and DON will observe weekly x4 weeks 5 residents requiring feeding assistance and adaptive equipment to ensure documentation is in patient's medical record. The result of the audits will be forwarded to the facility QAPI committee quarterly for 2 quarters for further review and recommendations.	

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F 677	Continued From page 2	F 677		

During a second interview on 4/25/19 at 9:15 AM, the ST stated that the resident's [redacted] precautions were communicated to the resident and staff and that staff were expected to follow ST recommendations. The ST stated that staff were supposed to ensure the resident sat upright, ate slowly and took small bites. The ST added that resident #10 was at risk for [redacted] and had and an "incident" in [redacted] and that was why the resident was referred to ST for evaluation.

Review of Resident #10's Progress Note dated [redacted] at 16:51 PM, signed by a Licensed Practical Nurse (LPN) revealed the following: Approached by Certified Nurses Aide (CNA) with concerns of resident coughing at breakfast meal. Staff wrote in the progress note that they spoke with ST to evaluate the resident's swallowing and to work with speech therapy.

Review of a second progress Noted dated 4/24/19 at 17:13, revealed that ST evaluated the resident and encouraged him/her to use a fork rather than spoon when eating. The progress Note further reflected for staff to continue with full feeding assistance of the resident as tolerated. The progress note reflected the resident stated that staff did not assist them with feeding and that he/she stated to the ST that; "I can feed myself, but I didn't use my fork, I used my hands."

Review of Resident #10's Care Plan (CP) dated [redacted] with a revision date of [redacted] showed the following:
"Encourage and assist as needed to consume foods and/or [redacted] and fluids offered at and between meals." In addition, it was noted that

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F 677	Continued From page 3 the resident needed full feeding assistance. Review of the facility's policy titled; Assistance with Meals and dated July 2017, showed the following: "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident." Under Policy Interpretation and Implementation Residents Confined to Bed: "The nursing staff will prepare residents for eating." "The nursing staff and/or Feeding Assistants will take food trays into resident's rooms." Under Residents Requiring Full Assistance: "Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity." 2. On 04/17/19 at 09:45 AM, during the initial tour of the facility, the surveyor observed Resident #88 awake in bed wearing a hospital gown. The resident's [redacted] appeared [redacted] The Admission Record reflected that Resident #88 was admitted to the facility on [redacted] The quarterly MDS dated [redacted] showed a BIMS score of [redacted] (meaning the resident was cognitively [redacted]. The resident's functional status reflected a two person assist for bed mobility, transfers and personal hygiene, and a one-person physical assist for eating. The MDS showed the resident had medical diagnoses that included; [redacted] On 04/22/19 at 12:25 PM, the surveyor entered	F 677		

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F 677	Continued From page 4	F 677		

Resident #88's room and noted the resident awake in bed with the overbed table placed over the resident's legs. There was a lunch tray on the over bed table with the food uncovered. The adaptive (built up) utensils on the food tray were placed on the resident's right side, ([redacted] of the resident was [redacted]. The surveyor noted two round pieces of roast beef, green beans, roasted potatoes and a container of milk on the food tray. The surveyor also noted that the roast beef was not cut up and the milk carton was unopened. The surveyor asked the resident if someone would come to cut the food up and set the resident up to eat. The resident replied; "sometimes they help me." The surveyor asked the resident how long the food had been in the room uncovered and the resident stated about ten minutes.

On 04/22/19 at 12:30 PM, the surveyor entered the resident's room with the resident's Certified Nurses Aide (CNA). The surveyor showed the CNA the plate of food and inquired about the process used for residents who needed assistance. The CNA stated that whoever delivered the trays was supposed to set the resident up for their meal by cutting up food and opening any containers. The CNA stated "this is not how you set up a residents tray, I didn't do this."

On 04/22/19 at 12:40 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN). The UM/LPN stated that whoever delivered the tray was responsible for preparing a resident's tray to meet their needs.

On 04/25/19 at 11:30 AM the surveyor reviewed the policy titled Assistance with Meals. Section

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F 677	Continued From page 5 three titled "Residents confined to bed". The policy reflected that nursing staff will prepare residents for eating." Review of the care plan showed a focus area of Activities of Daily Living (ADL) and self-care deficit related to [redacted] The care plan indicated a goal that the resident will receive assistance necessary to meet ADL needs. NJAC 8:39-22 (a)	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review it was determined that the facility failed to a.) check [redacted] functionality as ordered by the physician and b.) maintain the safety of residents by the inappropriate use of a power strip to connect medical devices. This deficient practice was identified for 1 of 26 residents (Resident #52) reviewed and 1 of 1 (Resident #46) reviewed for [redacted] use and was evidenced by the following: 1. According to the Admission Record (AR), Resident #52 was admitted to the facility with diagnoses that included: [redacted]	F 689	1. Resident #46 has not attempted to leave the facility and has remained safe throughout the stay at the Center. The power strip in residents #52's room and was immediately removed on 4/17/2019. 2. (a). Residents with wanderguards had the potential to be affected. Records reviewed and corrective action taken as necessary. (b) Residents with medical equipment powered by the power strips have the	5/15/19

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F 689	Continued From page 6 [redacted].	F 689	potential to be affected. Resident rooms assessed and no other medical equipment found to be powered by power strips.	

According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #52 had a Brief Interview for Mental Status score of [redacted] indicating the Resident's cognition was [redacted] impaired. The MDS further indicated that Resident #52 needed extensive assistance with Activities of Daily Living (ADLs).

0n 4/16/19 10:53 AM, the surveyor observed a power strip plugged into a red outlet in Resident #52's room. The following medical equipment were plugged into the power strip: [redacted] and [redacted].

During an interview on 4/17/19 at 11:00 AM, with a "Director of Maintenance (DOM)," the DOM stated "I didn't know there was a power strip in the room."
On 4/17/19 at 11:10 AM, the DOM removed the power strip from the resident's room.

Review of the facility's policy titled "Electrical Safety for Residents" dated January 2011, revealed the following:
Under Policy Statement: "The resident will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire. "

Under Policy Interpretation and Implementation: "Power strips shall not be used as a substitute for adequate electrical outlets in the facility. Power strips shall not be used with medical devices in resident-care areas."

3. (a) The DON provided education and in-service to nurses on 4/18/2019 which included the process of checking [redacted] placement and function using the [redacted] equipment and ensuring timely accurate documentation in the treatment record.

Each unit were provided an equipment to check wander guard. The [redacted] of resident #46 was checked for function and placement using the [redacted] equipment from 4/17/2019 to 4/26/2019 and noted to be in place and working. Resident #46 [redacted] will be checked daily or as needed throughout the stay at the Center.

The unit manager provided in-service to the nurses assigned to resident #46 on the process of checking [redacted] using the new equipment. Competency demonstrated.

(b) The DON, Maintenance Director and Unit Manager met the family of resident #52 and provided education. The education included appropriate use of electrical outlets and adherence to facility policy.

4.(a) The Unit Manager will continue to perform two audits weekly on

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F 689	Continued From page 7 2. On 04/17/19 at 10:08 AM, during the initial tour of the facility, the surveyor observed Resident #46wandering in the halls unassisted by staff. Shortly after the initial observation, the surveyor observed staff members redirecting the resident back to the unit from the day room. The Admission Record reflected that Resident #46 was admitted to the facility on [redacted] with medical diagnosis that included; [redacted] The quarterly MDS dated [redacted], showed a Brief Interview of Mental Status of [redacted] (meaning the resident had [redacted] impairment). The functional status reflected the resident required one-person physical assist for walking in the room and and in the corridor. The resident required "set up only" for locomotion off the unit. The [redacted] of the MDS under subset (E) for [redacted], was marked to indicate the resident used [redacted] daily. On 04/17/19 at 10:15 AM, the surveyor attempted to interview the resident, however, the resident was unable to be interviewed due to [redacted] impairment. On 04/18/19 at 09:00 AM, the surveyor observed the resident walking in the lobby area unassisted. On 04/18/19 at 10:15 AM, the surveyor was at the nurse's station and observed Resident #4 being escorted to the unit by two staff members. The surveyor then interviewed the unit Licensed	F 689	[redacted] checks and documentation in the TAR. Results of audits will be forwarded to the QAPI committee quarterly for 2 quarters for review and recommendations. (b) The Maintenance Director and Unit Manager will perform room checks at different times of the day to ensure Resident #52's family compliance weekly x4 weeks. The Maintenance Director will continue room checks for power strips in 5 rooms weekly x4 weeks. The results of the audits will be forwarded to the facility QAPI committee quarterly for 2 quarters for further review and recommendations.	

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F 689	Continued From page 8	F 689		

Practical Nurse who was seated at the nurse's station. The LPN stated that the resident "always walks off the unit and that's why there is a [redacted] on the resident."

On 04/18/19 at 11:00 AM, the surveyor reviewed the physician's order sheet (POS) in the electronic medical record (EMR). The POS reflected an order dated [redacted] for [redacted] and for staff to check placement and function of the [redacted] every shift. The surveyor then reviewed the current nursing care plan which included a focus on [redacted] risk with an intervention to check for placement and function of [redacted] as indicated.

On 04/18/19 at 11:02 AM, the surveyor reviewed the resident's treatment administration record (TAR) which reflected multiple blank slots on the TAR, indicating times that the [redacted] was not checked for functing by the nursing staff.

The [redacted] 2019 TAR showed five times on day shift, 13 times on evening shift, and two times on night shift when the [redacted] was not documented as checked.

In [redacted] of 2019 there were four times on day shift, 14 times on evening shift, and one time on night shift when the [redacted] was not documented as checked.

In [redacted] 2019, the [redacted] was not checked five times on day shift, nine times on evening shift, and one time on night shift.

On 04/22/19 at 09:55 AM, the surveyor interviewed Licensed Practical Nurse #1(LPN#1) regarding the checking of the [redacted].

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F 689	Continued From page 9 LPN #1 stated, "we don't have a device to check if the [redacted] was working, but the resident never attempts to leave." On 04/22/19 at 10:03 AM, the surveyor interviewed LPN #2 who stated; "we check for placement to see if it is on the [redacted]." She added; "we can walk the resident by a door to see if the [redacted] alarmed, and that's the only way to check for function. The LPN#2 did not stat she checked the [redacted] for functioning as ordered. On 04/22/19 at 11:00 AM, the Director of Nursing (DON) informed the surveyor that they had a device to check the [redacted] for functioning and that there was only one in the facility which they usually kept in the administrative offices. The DON stated that nursing staff were not aware that the device was in the administrative office. N.J.A.C# 8:39-27.1 N.J.A.C# 8:39-31.1(d)	F 689		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that Certified Nursing Assistants (CNA) received the	F 730	1. The three education files of Nurse Aides identified will have their educational requirements met and documented.	5/15/19

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F 730	Continued From page 10 required 12 hours of mandatory in-service training. This was identified for three of five CNA education files reviewed and was evidenced by the following: A review of five randomly selected staff in-service education files revealed that three of five CNA's did not have the required 12 hours of in-service training by their date anniversary hire dates. CNA #1 had a date of hire [redacted]. CNA #1 had completed 4.55 hours of in-service education. CNA #2 had a date of hire [redacted]. CNA #2 had completed 10.45 hours of in-service education. CNA #3 had a date of hire [redacted] CNA #3 had completed 9 hours of in-service education. On 4/24/19 at 12:00 P.M. the surveyor reviewed the staff education files that did not have the yearly required 12 hours of mandatory in-service training. The DON stated on 4/24/19 at 12:03 PM, that the hours in each CNA file were the only records the facility had. The DON stated the facility believed the previous Staff Educator either took some of the files or destroyed them. The facility did not provide evidence of 12 hour inservice education within their anniversary date. NJAC 8:39-43.17 (b)	F 730	2. No residents were impacted. 3. The ADON/FE will provide a complete 12 hour mandatory education and in-services to all CNAs. 4. The DON or DON designee will perform 5 audits of education files monthly x 6 months. Findings will be forwarded to QAPI committee quarterly for 2 quarters for further review and recommendations.	

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F 730	Continued From page 11	F 730		
F 921 SS=E	X Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions 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, interview, and record review, it was determined that the facility failed to maintain laundry dryers free of lint and dust. This deficient practice was identified in 2 of 2 dryers inspected and was evidenced by the following: On 4/24/19 at 10"00 AM, a tour of the facility's laundry room was conducted in the presence of a laundry Aide. The surveyor observed approximately 2 inches thick of lint in 2 of 2	F 921	1. Dryer Lint Traps are consistently checked, cleaned and documented on dryer Lint Trap Log per facility policy and procedure during hours of operation. 2. No residents were impacted. 3. The Environmental Services Director provided education and in-services on 4/24/2019 to environmental staff regarding the need to check and clean lint from the dryer lint traps and	5/15/19

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F 921	Continued From page 12 dryers. Upon interview on 4/24/19 at 10:00 AM, the Laundry Aide stated "I forgot to sign out the lint log." When asked what it meant when there was no employee initials on the Dryers Daily Lint Filter Cleaning Log, the Laundry Aide replied; "if the log wasn't filled, it means it wasn't done or someone wasn't working." In the presence the surveyor, the Laundry Aide proceeded to fill the lint log for 4/24/19 for 7:00 AM, and 9:00 AM. Review of the "Laundry Dryers Daily Lint Filter Cleaning Log" indicated the lint filter should be checked every 2 hours. Further review of the "Laundry Dryers Daily Lint Filter Cleaning Log" showed missing staff initials indicating the dryer lint was not checked for the following days and times: 12/1/18 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m.. 12/2/18 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m.. 12/5/18 Dryer #1 and Dryer #2 for 7:00 p.m.. 12/12/18 Dryer #1 and Dryer #2 for 5:00 p.m., and 7:00 p.m.. 12/13/18 Dryer #1 and Dryer #2 for 3:00 p.m., 5:00 p.m., and 7:00 p.m.. 12/15/18 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m.. 12/16/18 Dryer #1 and Dryer #2 for 7:00 a.m., and 9:00 a.m.. 12/17/18 Dryer #1 and Dryer #2 for 3:00 p.m., 5:00 p.m., and 7:00 p.m.. 12/21/18 Dryer #1 and Dryer #2 for 9:00 a.m., and 11:00 a.m..7:00	F 921	documentation on Lint Trap Log. 4. The Environmental Services Director will perform weekly audits x4 weeks of lint traps and Lint Tap Log documentation. Findings will be forwarded to QAPI committee quarterly for 2 quarters for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

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F 921	Continued From page 13	F 921		

12/27/18 Dryer #1 and Dryer #2 for 1:00 p.m., 3:00 p.m., 5:00 p.m., and 7:00 p.m..
12/31/18 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., 11:00 a.m.. and 5:00 p.m..
1/7/19 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m..
1/18/19 Dryer #1 and Dryer #2 for 3:00 p.m., 5:00 p.m., and 7:00 p.m..
1/21/19 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m..
1/27/19 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m..
1/28/19 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m..
2/23/19 Dryer #1 and Dryer #2 for 9:00 a.m., and 11:00 a.m..
2/25/19 Dryer #1 and Dryer #2 for 11:00 a.m..
3/23/19 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m..
3/24/19 Dryer #1 and Dryer #2 for 7:00 a.m., 9:00 a.m., and 11:00 a.m..

Review of the facility's undated policy titled "Dryer Fires" revealed the following:

Dryer fires are the single most critical issues facing the laundry department. Dryer fires are a threat to both employees and residents therefore; the utmost care and attention must be given by each employee to the cleaning and maintenance of the dryers. Linen Services is responsible for maintaining the laundry in a manner free from fire hazards and in a clean safe, and sanitary condition.

Under procedure:
(#1) Linen Service personnel are responsible for the following duties:
1.1- Clean lint from all dryers four (4) times a day

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F 921	Continued From page 14 1.2 -Clean lint from surfaces of equipment and from overhead pipes and structural members' daily. N.J.A.C 8:39-31.4(a)	F 921		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S2235	8:39-31.6(c) Mandatory Physical Environment (c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/2019 in the presence of facility management, it was determined that the facility failed to provide evacuation diagrams and post them on each resident care unit throughout the facility. This deficient practice was evidenced by the	S2235	1. Evacuation Maps are now posted in every Hallway. 2. The rest of the building was inspected for Evacuation Maps. 3. Maintenance personnel were educated	5/15/19

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

Electronically Signed | 05/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	04/25/2019

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S2235	Continued From page 1 following: During the survey entrance at 9:24 a.m., a request was made to the Administrator, Regional Director of Hospitality Services (RDHS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms in the facility. Starting at 9:34 a.m. during a tour of the building with the RDHS and MD the surveyor did not observe evacuation diagrams anywhere in the corridors throughout the facility. A review of the facility supplied lay-out identified that there are [redacted] resident sleeping rooms in the [redacted] section of the building and [redacted] resident sleeping rooms on the [redacted] section of the building. There was a Physical Therapy gym and a dining room. A second tour with the RDHS and MD was conducted at 1:55 p.m. The surveyor asked the RDHS and MD, if any emergency evacuation diagrams were posted in the facility. Along the tour, the RDHS pointed out to the surveyor one emergency evacuation diagram behind the Long Term Care Nursing station stored on the Residents Medical Records charting rack. The RDHS told the surveyor the evacuation diagrams may have been taken down during the wallpaper remodel project. The surveyor asked the RDHS, "When did the facility put up new wallpaper." The RDHS said, "Over a year ago."	S2235	about fire regulations and procedures as it relates to evacuation maps. 4. Maintenance Director will conduct 1X monthly visual check for 3 months to ensure that evacuation maps remain in place. Any findings will be reported to the QAPI committee quarterly for 2 quarters for further review and recommendations.	