

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3543AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGES OF GREEN VALLEY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2620 E ROBINDALE ROAD HENDERSON, NV 89074</b>		
(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) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of the annual state licensure survey and complaint investigation conducted at your facility on 10/29/08.</p> <p>The survey was conducted using Nevada Administrative Code (NAC)449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.</p> <p>The facility is licensed as a residential facility for groups to provide care for 103 residents (48 beds for elderly or disabled persons and 55 beds for persons with Alzheimer's disease or related dementia), Category 2 Residents.</p> <p>The census was 85. The sample size included 20 resident files and 14 employee files.</p> <p>The following complaints were investigated:</p> <p>Complaint #NV00018350 - Unsubstantiated Complaint #NV00018966 - Unsubstantiated Complaint #NV00016952 - Unsubstantiated Complaint #NV00017215 - Substantiated without deficiencies Complaint #NV00017663 - Substantiated without deficiencies</p> <p>The following regulatory deficiencies were identified:</p>	Y 000		
Y 435 SS=D	<p>449.229(4) Fire Extinguisher; Inspection</p> <p>NAC 449.229 4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by a person certified by the State Fire Marshall to</p>	Y 435		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 435	Continued From page 1 conduct such inspections.  This Regulation is not met as evidenced by: Based on observation, the facility failed to ensure 1 fire extinguisher was inspected, recharged, and tagged annually.  Findings include:  On 10/29/08, the fire extinguisher was observed propping open the front door of the kitchen. The tag on the fire extinguisher was dated 11/13/00. The fire extinguisher was undercharged.  Severity: 2                      Scope: 1	Y 435		
Y 444 SS=F	449.229(9) Smoke Detectors  NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility.  This Regulation is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the smoke detectors throughout the facility were tested on a monthly basis.  Findings include:  The facility was equipped with smoke detectors throughout the facility in each resident room, the main common living areas, and the administrative area near the front lobby.	Y 444		

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Y 444	Continued From page 2  Employee #11 was employed as the Director of Maintenance 3/7/08.  On 10/29/08, Employee #11 indicated he had not manually tested the smoke detectors throughout the facility. Employee #11 indicated he was unsure of how to test the smoke detectors, except by the absence of a lit button on each detector.  There was no documented evidence of monthly testing of the smoke detectors throughout the facility. (The only documented testing was listed on a report from a contracted company, which indicated annual testing of the smoke detectors located in each resident room.)  Severity: 2                      Scope: 3	Y 444		
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident  NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.  This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure that 4 of 20 residents received a physical	Y 859		

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Y 859	Continued From page 3 examination (Resident #3, #6, #8, #10).  Findings include:  Resident #3 was admitted on 5-5-07 with diagnoses including Osteoporosis and Senile Dementia. The initial physical examination was performed on 5-4-07. The resident's file did not contain the results of an annual physical examination of the resident by a physician for 2008.  Resident #6 was admitted on 5-24-07 with diagnoses including Breast Cancer, Hypertension, Depression, Stroke, Chronic Obstructive Pulmonary Disease and brain bleed. The initial physical examination was performed on 5-22-07. The resident's file did not contain the results of an annual physical examination of the resident by a physician for 2008.  Resident #8 was admitted on 4-23-05 with diagnosis of Depression. The resident's file did not contain the initial physical examination or an annual examination of the resident by a physician for 2006, 2007 and 2008.  Resident #10 was admitted on 9-28-08. The resident's file did not contain evidence of a documented initial physical examination of the resident by a physician. There was no listed diagnosis.  Severity: 2 Scope: 2	Y 859		
Y 876 SS=C	449.2742(4) NRS 449.037  NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the	Y 876		

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Y 876	Continued From page 4  administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met.  This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure an ultimate user agreement was signed for 20 of 20 residents.  Findings include:  On 10/29/08, record review of the 20 residents surveyed revealed:  Resident #1 was admitted on 2-9-08. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #2 was admitted on 9-25-08. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #3 was admitted on 5-4-07. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #4 was admitted on 5-13-06. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #5 was admitted on 8-27-08. The resident's file did not contain a signed ultimate	Y 876		

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Y 876	Continued From page 5  user agreement that authorized the facility to administer medications to the resident.  Resident #6 was admitted on 5-23-07. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #7 was admitted on 3-13-08. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #8 was admitted on 4-23-05. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #9 was admitted on 8-5-05. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #10 was admitted on 9-28-08. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #11 was admitted on 10/20/05. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #12 was admitted on 3/1/08. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #13 was admitted on 1/18/08. The resident's file did not contain a signed ultimate	Y 876		

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Y 876	<p>Continued From page 6</p> <p>user agreement that authorized the facility to administer medications to the resident.</p> <p>Resident #14 was admitted on 10/23/08. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.</p> <p>Resident #15 was admitted on 11/11/07. The resident's file did not contain a signed agreement to indicate the resident was responsible for his/her medications (self-medication management).</p> <p>Resident #16 was admitted on 8/22/07. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.</p> <p>Resident #17 was admitted on 8/9/07. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.</p> <p>Resident #18 was admitted on 7/25/05. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.</p> <p>Resident #19 was admitted on 7/22/07. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.</p> <p>Resident #20 was admitted on 3/30/07. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.</p> <p>On 10/29/08 at 3:00 PM, the facility administrator</p>	Y 876		

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Y 876	Continued From page 7  revealed, she was not aware of the needed documentation and therefore, confirmed that none of the residents had a signed agreement.  Severity: 1 Scope: 3	Y 876		
Y 883 SS=D	449.2742(7) Medication / Resident Refusal  NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.  This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of a missed medication for 1 of 20 residents. (Resident #1)  Findings include:  Resident #1 was admitted on 2-9-08 with diagnoses including Basal Corticoid Ganglionic Degeneration, Gastroesophageal Reflux Disease, Depression, Hypertension and contracture pain.  Methadone 10 milligrams (mg) was ordered to be given at 7am, 3pm and 9pm.  The medication administration record (MAR) showed documentation of the Methadone was not given on 10-23-08 at 3pm and 9pm, and on 10-24-08 at 7am, 3pm and 9pm.  Documentation on the MAR indicated the	Y 883		

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Y 883	Continued From page 8  medication was not given due to waiting for a prescription refill from the pharmacy.  There was no documented evidence the physician was notified of the missed medication.  On 10-30-08 at 4pm, Employee #13 revealed, the resident ran out of Methadone due to the resident requesting to be discharged from Hospice services on 10-18-08.  Severity: 2     Scope: 1	Y 883		
Y 936 SS=F	449.2749(1)(e) Resident file  NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.  This Regulation is not met as evidenced by: NAC 441A.380 is hereby amended to read as follows: 441A.380 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing, or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility.	Y 936		

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Y 936	Continued From page 9  2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing, or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu, or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician	Y 936		

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Y 936	Continued From page 10  determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home, or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that,	Y 936		

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Y 936	Continued From page 11  although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFB smears which were collected on separate days.  6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200.  7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.  8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person's medical record.  Based on record review, the facility failed to ensure 6 of 20 residents complied with NAC 441A.380 regarding tuberculosis (Resident #1, #3, #10, #13, #16, #17).  Findings include:  Review of resident files revealed:	Y 936		

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Y 936	Continued From page 12  Resident #1 was admitted on 2-9-08. The resident's file lacked documentation regarding compliance with NAC 441A TB skin testing.  Resident #3 was admitted on 5-5-07. The resident's file lacked documentation regarding compliance with NAC 441A TB skin testing.  Resident #10 was admitted on 9-28-08. The resident's file lacked documentation regarding compliance with NAC 441A TB skin testing.  Resident #13 was admitted on 1/18/08. The resident's file lacked documentation of the 2nd step TB screening being read. The 2nd step TB screening was provided on 11/6/07.  Resident #16 was admitted on 8/22/08. The resident's file lacked documentation regarding compliance with NAC 441A TB skin testing.  Resident #17 was admitted on 8/9/07. The resident's file lacked documentation regarding compliance with NAC 441A TB skin testing.  Severity: 2 Scope: 3  This is a repeat deficiency from the survey on 7-12-07.	Y 936		
Y 938 SS=D	449.2749(1)(g)(1) Resident file  NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against	Y 938		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3543AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGES OF GREEN VALLEY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2620 E ROBINDALE ROAD HENDERSON, NV 89074</b>		
(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) COMPLETE DATE
Y 938	Continued From page 13  unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident.  This Regulation is not met as evidenced by: Based on record review, the facility failed to perform an initial evaluation for 2 of 20 residents regarding their abilities to perform the activities of daily living (ADL).  Findings include:  Resident #5 was admitted on 8-27-08. The resident's file did not contain evidence of a documented initial ADL assessment.  Resident #8 was admitted on 4-23-05. The resident's file did not contain evidence of a documented initial ADL assessment.  Severity: 2 Scope: 1	Y 938		
Y 940 SS=D	449.2749(1)(g)(3) Resident file  NAC 449.2749 1. A separate file must be maintained for each	Y 940		

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Y 940	Continued From page 14  resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (3) In any event, not less than once each year.  This Regulation is not met as evidenced by: Based on record review on 10-29-08, the facility failed to perform an annual evaluation of a resident's ability to perform the activities of daily living for 1 of 20 residents residing in the facility longer than a year (Resident #8).  Findings include:  Resident #8 was admitted on 4-23-05. The resident's file did not contain an annual evaluation of the resident's ability to perform the activities of daily living for 2008.  Severity: 2 Scope: 1	Y 940		
Y 991 SS=E	449.2756(1)(b) Alzheimer's Fac door alarm  NAC 449.2756 1. The administrator of a residential facility which	Y 991		

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Y 991	<p>Continued From page 15</p> <p>provides care to persons with Alzheimer's disease shall ensure that:</p> <p>(b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility.</p> <p>This Regulation is not met as evidenced by: Based on observation, the facility failed to ensure doors into 3 of 5 Alzheimer's Units were equipped with operational alarms, buzzers, horns or other audible devices activated upon opening of the door.</p> <p>Findings include:</p> <p>On 10/29/08, the following doors to 3 Alzheimer's Units (Oak Cottage, Elm Cottage, and Maple Cottage) were not equipped with an audible alarm:</p> <p>The door leading from the front lobby to the Oak Cottage was not equipped with an alarm which was audible to the interior of the unit upon opening of the door. The front doors of the Elm Cottage and the Maple Cottage were not equipped with an audible alarm initiated upon the opening of the doors.</p> <p>On 10/29/08 in the morning and afternoon, the doors leading from the Oak Cottage and the Elm Cottage to the shared courtyard were ajar and held open with rocking chairs. There was no audible alarm initiated when a resident walked to and from the courtyard between the Oak Cottage and the Elm Cottage.</p>	Y 991		

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Y 991	Continued From page 16 Severity: 2                      Scope: 2  Repeat Deficiency: 7/12/07	Y 991		
Y 994 SS=E	449.2756(1)(e) Alzheimer's fac knives  NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents.  This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure knives and other kitchen tools were not accessible to residents with Alzheimer's disease or related dementia.  Findings include:  On 10/29/08 in the evening, the administrator indicated there was no secure yard for the residents of the White Cottage and the Purple Cottage, 2 of 5 cottages for residents with Alzheimer's disease or related dementia. The administrator further indicated the residents utilize the common courtyard in the center of the facility as an outdoor activity area.  On 10-29-08 in the morning, during the initial tour of the facility, the Oak cottage kitchen contained a drawer with table knives, cheese grater and pie	Y 994		

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Y 994	Continued From page 17  cutter. The gate to the kitchen area was unable to be secured. Bandage scissors were identified on the dresser in Resident room 204A.  On 10-29-08 in the morning during the initial tour of the facility, a resident was sitting in a chair in room 1005. There were a pair of scissors located beside the resident.  Severity: 2 Scope: 2	Y 994		
Y 999 SS=E	449.2754(1)(g) Alzheimer's Facility  NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility.  This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents with Alzheimer's disease or related dementia.  Findings include:  On 10/29/08 in the evening, the administrator indicated there was no secure yard for the residents of the White Cottage and the Purple Cottage, 2 of 5 cottages for residents with Alzheimer's disease or related dementia. The administrator further indicated the residents utilize the common courtyard in the center of the	Y 999		

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Y 999	<p>Continued From page 18</p> <p>facility as an outdoor activity area.</p> <p>On 10/29/08 in the morning and afternoon, the doors to the 5 unsecured (Non-Alzheimer) cottages (Blue Cottage, Green Cottage, Red Cottage, and Yellow Cottage) were unlocked and accessible from the Main Courtyard. Each of these cottages contained a kitchen with accessible kitchen tools.</p> <p>On 10/29/08 in the morning and afternoon, there was a cart stored in the Main Courtyard near the door to the Oak Cottage. The cart had multiple containers of toxic liquids, including 2 cans of "Goof Off", 2 cans of spray paint, and 1 can of spray adhesive.</p> <p>On 10-29-08 in the afternoon, during a tour of the facility, Kleen guard was located in a cupboard in the main living area of the Purple cottage.</p> <p>On 10-29-08 in the afternoon, during a tour of the facility, the following items were identified under the bathroom sink in room 908: Nivea body lotion, soft soap, enchanted orchid lotion, sweet pea lotion, skin care lotion, pond's lotion, pantene 2-1 shampoo (2 bottles) and vanilla body scrub. The items were located in a wash basin.</p> <p>On 10/29/08 at 2:15 PM, a spray can of lemon oil was found in the vanity drawer.</p> <p>Severity: 2      Scope: 2</p> <p>This is a repeat deficiency from the survey on 7-12-07.</p>	Y 999		

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