

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E244	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2012
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NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 9, 10, 11, and 12, 2012</p> <p>Facility number: 000388 Provider number: 15E244 AIM number: 100454140</p> <p>Survey team: Karina Gates BHS TC Courtney Mujic RN Barbara Hughes RN Beth Walsh RN</p> <p>Census bed type: NF: 41 Total: 41</p> <p>Census payor type: Medicaid: 41 Total: 41</p> <p>Sample: 11 Supplemental sample: 13</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/22/12 by</p>	F0000	<p>This plan of correction is to serve as Rural Health Care's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Rural Health Care or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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	Jennie Bartelt, RN.			
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F0164 SS=B	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review, and interview, the facility failed to provide a place to meet privately with visitors for 1 of 3 residents reviewed for privacy in a sample of 11 (Resident #41) and 3 of 11 residents interviewed for privacy in the group meeting of 11 residents. (Residents #2, #22, and #7)</p> <p>Findings include:</p>	F0164	<p>F164 483.10(e) PRIVACY AND CONFIDENTIALITY</p> <p>It is the practice of Rural Health Care to ensure the resident's right to privacy and confidentiality of personal and clinical records.</p> <p>I. Residents #41, #2, #22, and #7</p>	02/10/2012
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	<p>An interview was conducted with Resident #41 on 1/11/12 at 3:05 p.m. During the interview, she indicated she is not able to meet privately with her visitors if her roommate is present in the room and someone is always in the dining room. She indicated the only time she has privacy is in the bathroom.</p> <p>During a group interview on 1/10/12 at 3:15 p.m., Resident #2, Resident #22, and Resident #7 indicated they do not have anywhere to meet privately with visitors.</p> <p>Immediately before this group interview, the Activity Assistant provided a list of 11 residents who attended group which included Residents #2, #22, and #7. Review of the list indicated all 11 residents were interviewable.</p> <p>Observations of the dining room were made on 1/9/12 from 10:00 a.m. until 3:00 p.m., 1/10/12 from 10:00 a.m. until 6:30 p.m., 1/11/12 from 10:00 a.m. until 5:20 p.m., and 1/12/12 from 10:00 a.m. until 6:30 p.m. During these time periods, the dining room was in consistent use for multiple purposes, including all meals, activities, resident council, lounging, socializing, and watching television and unavailable for a private meeting with visitors .</p>		<p>have been informed of the location for private meetings.</p> <p>II. All residents have the potential to be affected.</p> <p>III. The facility has made available a room for residents to utilize when they desire a private meeting room. Residents have been informed of this new location during Resident Council Meeting. This room is available 24 hours a day 7 days a week. Facility personnel have been inserviced on this location.</p> <p>IV. The Director of Social Services or his designee is conducting quality improvement audits to ensure residents are aware of the private meeting room. A random sample of 4 residents are interviewed weekly for 30 days; then monthly for 6 months to ensure they are aware of the private meeting room location. Results of these interviews are discussed during the facility's QA meeting monthly.</p>				

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	<p>During interview with the DON on 1/12/12 at 2:00 p.m., she indicated if a resident's family wanted to have private meetings with the resident, she or the Social Services Director would let them use one of their offices, but hadn't informed the residents of this.</p> <p>During interview with the Social Services Director on 1/12/12 at 2:45 p.m., he indicated he would offer his office to residents and their visitors if they asked, but never informed residents that if they wanted to meet privately, his office was available.</p> <p>3.1-3(p)(5)</p>				

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F0223 SS=D	<p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse by staff for 1 of 8 residents reviewed related to allegations of abuse in 5 facility abuse investigations reviewed for implementation of adequate abuse procedures. (Resident #13)</p> <p>Findings include:</p> <p>Review of a report to the Indiana State Department of Health, written 4/21/11 by the Administrator, indicated on 4/21/11 CNA #12 reported that Resident #13 was verbally abused by an LPN two days earlier, on 4/19/11. The LPN was immediately suspended pending investigation.</p> <p>On 1/12/12 at 12:15 p.m. the Administrator provided a copy of information pertaining to the above incident. Review of the statement given by CNA #13 indicated on 4/19/11 Resident #13 called the LPN a mother f--- and the LPN responded by calling the resident the same thing back. Review of</p>	F0223	F223 483.13(b) ABUSE It is the practice of Rural Health Care to ensure the resident right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. I. Resident #13 was interviewed at the time of this incident 9 months ago and this has been resolved. As indicated in the survey report the LPN involved is no longer employed by the facility; CNA #12 and CNA #13 were re-educated at the time of the incident regarding the facility Abuse Policy but no longer work at the facility. II. The facility conducted random resident and staff interviews following this incident to ensure no other residents were affected. III. As indicated in the survey report the facility has an Abuse Prevention Policy. Following this incident, staff were re-educated on this policy. This education is repeated quarterly with facility personnel and is provided to all new employees at the time of hire. Residents were re-educated about their right to be free from abuse. Residents will be re-educated on a quarterly basis and prn. IV. The DON or her	02/10/2012			

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	<p>the statement provided by CNA #12 indicated on 4/19/11 Resident #13 yelled "F--- you b----." The LPN then stated "F--- you too. Get out of my face. I don't want you looking me in my face." The abuse investigation conclusion indicated it was determined that Resident #13 was verbally abused and the LPN was terminated immediately. CNA #12 and CNA #13 were issued corrective actions for violating the facility's abuse policy and re-educated on the abuse policy.</p> <p>During interview with the DON (Director of Nursing) on 1/12/12 at 10:05 a.m., she indicated the staff knew abuse of any kind was not tolerated and stated, "The Administrator and I expect staff to call us immediately and at anytime to report abuse."</p> <p>The facility's abuse policy was provided by the Administrator on 1/9/12 at 1:00 p.m. The policy indicated the facility will not condone any form of resident abuse and that each resident will be provided with an environment that is free from verbal abuse. The policy indicated the Administrator or DON must be immediately notified of suspected abuse, allegations of abuse, or incidents of abuse. Personnel are to report abuse/neglect to their supervisor or to the DON, in which case, the Administrator</p>		<p>designee conducted random resident and staff interviews regarding the abuse policy following this incident nine months ago. As part of our ongoing facility QA process 4 random personnel are being interviewed monthly to ensure understanding of the facility abuse prevention program. Results of these interviews are discussed during the facility's QA meeting monthly.</p>				

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	<p>should then be notified immediately.</p> <p>3.1-27(b)</p>			
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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure the supervisor was notified immediately and the Administrator was notified within 24</p>	F0225	F225 483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT/ ALLEGATIONS/INDIVIDUALS It is the practice of Rural Health Care to ensure that all alleged	02/10/2012

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	<p>hours of an allegation of verbal abuse. The deficient practice affected 1 of 8 residents reviewed related to allegations of abuse in 5 facility abuse investigations reviewed for implementation of adequate abuse procedures. (Resident #13)</p> <p>Findings include:</p> <p>Review of a report to the Indiana State Department of Health, written 4/21/11 by the Administrator, indicated on 4/21/11 CNA #12 reported that Resident #13 was verbally abused by an LPN 2 days earlier, on 4/19/11. The LPN was immediately suspended pending investigation.</p> <p>On 1/12/12 at 12:15 p.m. the Administrator provided a copy of information pertaining to the above incident. Review of the statement given by CNA #13 indicated on 4/19/11 Resident #13 called the LPN a m----- f---- - and the LPN responded by calling the resident the same thing back. Review of the statement provided by CNA #12 indicated on 4/19/11 Resident #13 yelled "F--- you b----." The LPN then stated "F-- you too. Get out of my face. I don't want you looking me in my face." The abuse investigation conclusion indicated it was determined that Resident #13 was verbally abused and the LPN was terminated immediately. CNA #12 and</p>		<p>violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures including to the state survey and certification agency. I. Resident #13 was interviewed at the time of this incident 9 months ago and this has been resolved. As indicated in the survey report the LPN involved is no longer employed by the facility; CNA #12 and CNA #13 were re-educated at the time of the incident regarding the facility Abuse Policy but are no longer employed at the facility. II. The facility conducted random resident and staff interviews following this incident to ensure no other residents were affected. III. As indicated in the survey report the facility has an Abuse Prevention Policy. Following this incident, staff were re-educated on this policy. This education is repeated quarterly with facility personnel and is provided to all new employees at the time of hire. Residents were re-educated about their right to be free from abuse. Residents will be re-educated on a quarterly basis and prn. IV. The DON or her designee conducted random resident and staff interviews regarding the abuse policy following this incident nine</p>		

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	<p>CNA #13 were issued corrective actions for violating the facility's abuse policy and re-educated on the abuse policy.</p> <p>During interview with the DON (Director of Nursing) on 1/12/12 at 10:05 a.m., she indicated the staff knew abuse of any kind was not tolerated and stated, "The Administrator and I expect staff to call us immediately and at anytime to report abuse."</p> <p>The facility's abuse policy was provided by the Administrator on 1/9/12 at 1:00 p.m. The policy indicated the facility will not condone any form of resident abuse and that each resident will be provided with an environment that is free from verbal abuse. The policy indicated the Administrator or DON must be immediately notified of suspected abuse, allegations of abuse, or incidents of abuse. Personnel are to report abuse/neglect to their supervisor or to the DON, in which case, the Administrator should then be notified immediately.</p> <p>3.1-28(c)</p>		<p>months ago. As part of our ongoing facility QA process 4 random personnel are being interviewed monthly to ensure understanding of the facility abuse prevention program including the need to report immediately to the Administrator. Results of these interviews are discussed during the facility's QA meeting monthly.</p>		

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F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure nursing assistants followed facility policy by reporting allegations of verbal abuse towards a resident to their supervisor immediately as required by facility policy for 1 of 8 residents reviewed related to allegations of abuse in 5 facility abuse investigations reviewed for implementation of adequate abuse procedures. (Resident #13)</p> <p>Findings include:</p> <p>The facility's abuse policy was provided by the Administrator on 1/9/12 at 1:00 p.m. Review of the policy indicated the facility will not condone any form of resident abuse and that each resident will be provided with an environment that is free from verbal abuse. The policy indicated the Administrator or DON (Director of Nursing) must be immediately notified of suspected abuse, allegations of abuse, or incidents of abuse. Personal are to report abuse/neglect to their supervisor or to the DON, in which case, the Administrator should then be notified immediately</p> <p>Review of a report to the Indiana State</p>	F0226	<p>F226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT POLICIES It is the practice of Rural Health Care to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property. I. Resident #13 was interviewed at the time of this incident 9 months ago and this has been resolved. As indicated in the survey report the LPN involved is no longer employed by the facility; CNA #12 and CNA #13 were re-educated at the time of the incident regarding the facility Abuse Policy but are no longer employed at the facility. II. The facility conducted random resident and staff interviews following this incident to ensure no other residents were affected. III. As indicated in the survey report the facility has an Abuse Prevention Policy. Following this incident, staff were re-educated on this policy. This education is repeated quarterly with facility personnel and is provided to all new employees at the time of hire. Residents were re-educated about their right to be free from abuse. Residents will be re-educated on a quarterly basis and prn. IV. The DON or her designee conducted random</p>	02/10/2012			

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	<p>Department of Health, written 4/21/11 by the Administrator, indicated on 4/21/11 CNA #12 reported that Resident #13 was verbally abused by an LPN 2 days earlier, on 4/19/11. The LPN was immediately suspended pending investigation.</p> <p>On 1/12/12 at 12:15 p.m. the administrator provided a copy of information pertaining to the above incident. Review of the statement given by CNA #13 indicated on 4/19/11 Resident #13 called the LPN a m----- f---- - and the LPN responded by calling the resident the same thing back. Review of the statement provided by CNA #12 indicated on 4/19/11 Resident #13 yelled, "F--- you b----." The LPN then stated, "F-- you too. Get out of my face. I don't want you looking me in my face." The abuse investigation conclusion indicated it was determined that Resident #13 was verbally abused, and the LPN was terminated immediately. CNA #12 and CNA #13 were issued corrective actions for violating the facility's abuse policy and re-educated on the abuse policy.</p> <p>During interview with the DON on 1/12/12 at 10:05 a.m., she indicated the staff knew abuse of any kind was not tolerated and stated, "The Administrator and I expect staff to call us immediately and at anytime to report abuse."</p>		resident and staff interviews regarding the abuse policy following this incident nine months ago. As part of our ongoing facility QA process 4 random personnel are being interviewed monthly to ensure understanding of the facility abuse prevention program. Results of these interviews are discussed during the facility's QA meeting monthly.				

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	3.1-28(a)			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E244		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2012	
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F0241 SS=E	<p>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.</p> <p>Based on observation and interview, the facility failed to ensure dependent residents were assisted to maintain a dignified appearance by wearing clean clothing and eyeglasses and had proper hygiene. The facility also failed to ensure staff did not discuss resident care needs in the hallway. The deficient practice affected 5 of 11 residents in a sample of 11 and 3 of 13 residents in a supplemental sample of 13 reviewed for cleanliness. (Residents #12, #32, #29, #25, #2, #14, #38 and #13)</p> <p>Findings include:</p> <p>1. During observation on 1/10/2012 at 3:50 p. m., in the hallway outside room 20, LPN#7 stuck her head out of Resident #25's room and yelled to LPN #2, "Can you have someone bring me a brief for (name of Resident #25) ?" LPN #2 replied by yelling, "What size does he use?" LPN #7 replied by yelling, "Medium."</p> <p>2. Resident #13 was observed on 1/11/2012 at 4:00 p. m. at the nurse's station, and on 1/12/2012 at 9:20 a.m., in the hallway across from the kitchen,</p>	F0241	<p>F241 483.15(a) DIGNITY</p> <p>It is the practice of Rural Health Care to 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.</p> <p>I. Resident #25 was not affected by the comment regarding provision of a brief; Resident #13 is being assisted with clean shoes and socks daily; Resident #32 is wearing clean clothing; Resident #14 has been showered and mouth care performed; Resident #29 eyeglasses were cleaned; Resident #2 is wearing clean clothing; Resident #12 has had nail care; Resident #38 is wearing clean clothing.</p> <p>II. All residents have the potential to be affected. This is being addressed by the systems described below.</p>	02/10/2012			

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	<p>wearing visibly dirty socks with no shoes.</p> <p>3. Resident #32 was observed on the following dates and times: 1/9/2012 at 9:50 a.m., 1/10/2012 at 10:15 a.m., 1/11/2012 at 11:15 a.m. and 1/12/2012 at 10:00 a.m. At each observation Resident #32 was wearing the same outfit: a dark blue sweatshirt and food stained dark green sweatpants.</p> <p>4. On 1/10/2012 at 10:30 a.m. in his wheelchair in front of the nurse's station, Resident #14 was observed to have a foul body odor, and he had white colored food stuck between his teeth.</p> <p>5. On 1/9/2012 at 1:55 p.m., Resident #29 was observed lying in bed wearing eyeglasses. During interview at this time, Resident #29 indicated he could not see because his eyeglasses were dirty. The resident's eyeglasses were visibly soiled with greasy smudges.</p> <p>6. On 1/11/12 at 4:20 p.m., Resident #2 was observed near room #3 with multiple tears/rips in his gray t-shirt, on his right side, and several stains on the front of his t-shirt.</p> <p>On 1/11/2012 at 12:40 p.m. and at 3:18 p.m., Resident #2 was observed to wear a short sleeved gray colored t-shirt with</p>		<p>III. Nursing personnel have been re-educated on the importance of assistance with ADL care including clean clothing in good repair, clean eyeglasses, nail care, mouth care, and personal hygiene. This education also stressed the importance of not discussing resident needs in common areas. Additional systemic changes are being implemented through our quality improvement process as described in IV.</p> <p>IV. The DON or her designee is conducting QI dignity audits of resident care. A random sample of 4 residents are being checked weekly for 30 days; then 4 residents every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>				

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	<p>several food stains down the front and multiple small holes under the right armpit.</p> <p>7. Resident #12's clinical record was reviewed on 1/9/2012 at 1:45 p.m. The record indicated diagnoses that included, but were not limited to, infantile cerebral palsy and organic brain damage.</p> <p>During observation of Resident #12 on 1/12/2012 at 10:30 a.m., she had contracted hands where her fingers were clenched into a fist and long fingernails. Interview with LPN #2 during the observation indicated that the nursing staff is responsible for nail care but she didn't think that Resident #12's nails were too long.</p> <p>Resident #12's most recent RAI (Resident Assessment Instrument) assessment dated 12/16/2011 for hygiene was coded for total dependence and one person physical assist.</p> <p>8. On 1/10/12 at 3:05 p.m., Resident #38 was observed in the area between the business office and dining room with multiple wet stains on the front of her purple sweatshirt.</p> <p>In an interview with the DoN (Director of Nursing) and ADoN (Assistant Director</p>						

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	<p>of Nursing) on 1/12/12 at 10:35 a.m., they indicated that their expectation was that staff is to immediately change residents' clothing that is soiled or torn. If a resident's clothing is torn, the resident's family member is to be called to be notified new clothing is needed for the resident.</p> <p>3.1-3(t)</p>			
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F0252 SS=E	<p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure spills were cleaned up in a timely manner for 2 of 11 residents whose rooms were observed for cleanliness in a sample of 11. The facility also failed to provide private closet space for the closet shared by 2 residents. The deficient practice affected 1 of 1 resident in the sample of 11 and 1 of 1 resident in the supplemental sample of 13 reviewed for closet space. (Residents #25, #26, #38, and #1)</p> <p>Findings include:</p> <p>1. During an observation on 1/9/12 at 11:30 a.m., Resident #38 was sitting in her room in her wheelchair. She had popcorn scattered at arm's length around her wheelchair in the middle of the room extending to under a bed. The scattered popcorn could be observed from the hallway, in front of the resident's room. LPN #2 was observed entering the resident's room at 11:45 a.m. and she wheeled out the resident to the dining room. The popcorn remained in the middle of the room and under the bed. CNA#3 was observed entering the resident's room at 12:00 p.m. and she walked out the resident's room without</p>	F0252	<p>F252 483.15(h)(1) ENVIRONMENT</p> <p>It is the practice of Rural Health Care to provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>I. Resident #38 and #1 rooms were cleaned during the survey. The closet divider for Resident #25 & #26 was repaired.</p> <p>II. All residents have the potential to be affected. Closets of resident rooms have been checked to ensure there are no other dividers in need of repair.</p> <p>III. Facility personnel have been educated regarding the importance of prompt attention to any food, trash, or spills on the floor. This education also stressed the importance of completing a work order to notify</p>	02/10/2012			

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	<p>calling housekeeping or cleaning up the spilled popcorn. The popcorn remained throughout the middle of the room and under the bed until 1:30 p.m., when housekeeping cleaned up the scattered popcorn.</p> <p>2. During an observation in Resident #1's room, on 1/12/12 at 10:30 a.m., water was puddled from a nightstand at the edge of the room to the middle of the room with a cup laying on its side near the puddle. The water puddle was clearly visible from the hallway. At 10:40 a.m., CNA #4 walked into the resident's room and walked back out shortly after entering the room. At 11:20 a.m., the water puddle still remained from the edge of the nightstand to the middle of the room.</p> <p>During an interview with the DoN (Director of Nursing) on 1/12/12 at 10:40 a.m., she indicated that all staff is to pick/clean up discarded food, trash, and spills, it's not just housekeeping's responsibility, and it should be done immediately.</p> <p>3. During an observation on 1/10/12 at 9:45 A.M., the single bedroom closet utilized by both Residents #25 and #26 was observed to be in disarray with clothing on the top shelving laying crosswise with no separation, and</p>		<p>the maintenance department when there are closets rods and dividers in need of repair. Additional systemic changes are being implemented through our quality improvement process as described in IV.</p> <p>IV. The DON or her designee is conducting quality improvement audits to ensure spills are promptly cleaned. These audits are being completed weekly at random times throughout the day for 30 days; then monthly for 6 months. This audit will include checking the closet of the randomly chosen room to ensure the closet dividers are in place. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>		

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	<p>clothing laying on the bottom of the closet was also covering both sides of the space. A divider (appearing to be about 12 inches wide) was located in the center of the closet, running from the top shelving down to the floor, but was too small to keep the clothing from intermingling at the bottom. There was no divider from the top shelving up to the ceiling measuring a distance of 5 feet.</p> <p>During an interview with LPN # 14 on 1/10/12 at 2:45 P.M., she stated "That's just the way it is, but I don't think it is right" and indicated it was difficult to identify which resident owned the clothing.</p> <p>3.1-19(f)(5)</p>			
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F0282 SS=E	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow physician orders for 3 of 11 residents reviewed for following physician's orders in a sample of 11 and 1 of 1 resident reviewed for following physician's orders in a supplemental sample of 13. (Residents #38, #1, #24, and #12)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #38 was reviewed on 1/9/12 at 11:30 a.m.</p> <p>The diagnoses for Resident #38 included, but were not limited to, schizophrenia, paranoia, dementia, hypertension, anemia, thrombocytopenia, and diabetes mellitus.</p> <p>A recapitulation of the January 2012 Physician's Orders indicated that a fasting lipid panel and AST/ALT (liver blood test) was to be completed every 6 months.</p> <p>The initial order, dated 6/28/10, indicated a fasting lipid panel and AST/ALT was to be completed every 6 months.</p> <p>The last results for a fasting lipid panel and AST/ALT was on 5/18/11.</p>	F0282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN</p> <p>It is the practice of Rural Health Care to provide services by qualified persons in accordance with each resident's written plan of care.</p> <p>I. The lab test has been completed for Resident #38. The physician for Resident #1 was notified of the error in insulin dosage. Resident #12 is receiving the lotion to her feet as ordered. The physician for Resident #24 was notified of the error in insulin dosage.</p> <p>II. All residents have the potential to be affected by missing lab tests and treatments. The orders and medication administration records (MAR) for residents receiving insulin have been audited to ensure residents are receiving insulin as ordered.</p>	02/10/2012			

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	<p>In an interview with the ADoN (Assistant Director of Nursing) on 1/12/12 at 10:30, he indicated there was a miscommunication with the lab and the missing labs were not done. He also indicated that there was incorrect documentation done in their lab communication log that the labs were actually completed when they were not.</p> <p>2. The clinical record for Resident #1 was reviewed on 1/11/12 at 3:25 p.m.</p> <p>The diagnoses for Resident #1 included, but were not limited to, diabetes mellitus.</p> <p>A recapitulation of the November 2011 Physician's Orders indicated Novolog (insulin) was to be given on a sliding scale coverage for subsequent Accucheck (test for blood glucose) measurements. The Novolog sliding scale indicated that Accucheck measurements of 151-200=2 units of Novolog, 201-250= 4 units of Novolog, 251-300=6 units of Novolog, 301-350=8 units of Novolog, 351-400=10 units of Novolog.</p> <p>The November 2011 Fingertstick and Insulin Administration Form indicated that on 11/1/11 that an Accucheck measurement at 6 a.m., was 249. According to the physician order, 4 units of Novolog were to be given, but 0 units</p>		<p>III. Nursing personnel have been re-educated regarding the importance of following physician's orders including the plan of care. A lab tracking tool has been implemented that allows the facility to track that the lab ordered has been done and the results received. In addition, the facility has implemented a separate notebook to contain the diabetic flow sheets and insulin administration records. This diabetic book as well as the lab tracking book will be reviewed daily during morning clinical meeting to further ensure documentation and accuracy.</p> <p>IV. The DON or her designee is conducting quality improvement audits to ensure compliance with following the plan of care. A random sample of 4 residents are being checked weekly for 30 days; then monthly for 6 months to ensure that treatments are performed as ordered, labs are completed as ordered and insulin is administered as ordered. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>		

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	<p>were given as indicated by the form. On 11/2/11 at 4:00 p.m., an Accucheck measurement of 157 was obtained. According to the physician's order, 2 units of Novolog were to be given and 0 units were given as indicated, by the form.</p> <p>On 11/13/11 at 6:00 a.m., an Accucheck measurement of 294 was obtained. According to the physician's order, 6 units of Novolog were to be given and 2 units were given as indicated, by the form.</p> <p>On 11/13/11 at 4:00 p.m., an Accucheck measurement of 208 was obtained. According to the physician's order, 4 units of Novolog were to be given and 2 units were given as indicated, on the form.</p> <p>In an interview with the ADoN (Assistant Director of Nursing) on 1/12/12 at 1:25 p.m., he indicated that he had no explanation for the incorrect units of Novolog that were given as indicated by the November 2011 Fingerstick and Insulin Administration Form. He also indicated that staff are to follow physician's orders at all times.</p> <p>3. Resident #12's clinical record was reviewed on 1/9/2012 at 1:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, infantile cerebral palsy and organic brain damage.</p>				

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	<p>Record review of a Physician's order dated 12/08/2011 indicated apply lotion to bilateral (both) feet after showers.</p> <p>On 1/12/2012 at 10:30 a.m., Resident #12 was observed during a skin assessment after her shower. Her feet were dry and did not have any visible lotion on them.</p> <p>Interview with CNA #6 on 1/12/2012 at 1:20 p.m. indicated she did not put any lotion on Resident #12's feet because she did not know she was supposed to apply lotion to her feet but would find out from the nurse if this had been ordered.</p> <p>4. A physician's recap order dated 1/1/12 called for Resident # 24 to receive 12 units of Novolog insulin to be given (regularly scheduled) at lunch. LPN # 2 combined this order of 12 units with an amount indicated by blood sugar taken for sliding scale coverage. From January 1 to the 10th, the following incorrect amounts of insulin were administered.</p> <p>The Fingerstick Form for January 2012 indicated the following (incorrect) sliding scale:</p> <p>151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units</p>				

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	<p>Physician order, dated 11/30/11, and included on the January 2012 physician's recapitulation orders, indicated the following units of Novolog be administered according to the sliding scale as follows:</p> <p>201 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units 351 - 400 = 8 units 401 - 450 = 10 units</p> <p>Incorrect doses given are as follows: (BS = blood sugar)</p> <p>1/1/12 11:00 A.M., BS 292, 6 units given, should have been 4 units 1/2/12 11:00 A.M., BS 225, 4 units given, should have been 2 units 4:00 P.M., BS 161, 2 units given, should have been 0 units 9:00 P.M., BS 242, 4 units given, should have been 2 units 1/3/12 11:00 A.M., BS 191, 2 units given, should have been 0 units 4:00 P.M., BS 152, 2 units given, should have been 0 units 9:00 P.M., BS 225, 4 units given, should have been 2 units 1/4/12 4:00 P.M., BS 151, 2 units given, should have been 0 units 9:00 P.M., BS 192, 2 units given,</p>			
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	<p>should have been 0 units 1/5/12 11:00 A.M., BS 207, 4 units given, should have been 2 units 4:00 P.M., BS 239, 4 units given, should have been 2 units 1/6/12 11:00 A.M., BS 236, 4 units given, should have been 2 units 4:00 P.M., BS 250, 8 units given, should have been 2 units 9:00 P.M., BS 270, 6 units given, should have been 4 units 1/7/12 11:00 A.M., BS 201, 4 units given, should have been 2 units 9:00 P.M., BS 233, 4 units given, should have been 2 units 1/8/12 9:00 P.M., BS 236, 4 units given, should have been 2 units 1/9/12 11:00 A.M.,BS 189, 2 units given, should have been 0 units 4:00 P.M., BS 209, 4 units given, should have been 2 units 9:00 P.M., BS 317, 8 units given, should have been 6 units 1/10/12 11:00 A.M., BS 293, 6 units given, should have been 4 units</p> <p>3.1-35(g)(2)</p>						

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F0323 SS=E	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, record review, and interview, the facility failed to ensure safety when syringes with exposed needles were carried by LPN #2 down the hallway when exiting resident rooms after being used to administer medications. This had the potential to affect 22 residents residing in the rear hallway of 41 residents in the facility. The deficient practice occurred for 2 of 2 residents observed receiving injections during 2 of 40 medication passes. (Residents # 9 and #6)</p> <p>B. Based on observation, record review, and interview, the facility failed to protect the resident from potential accident during a transfer for 1 of 2 residents observed during a transfer in a sample of 11. (Resident #16)</p> <p>C. Based on observation and interview, the facility failed to ensure safe water temperatures for the resident shower room, potentially affecting 29 of 40 residents who used the shower room. These residents were not bedfast and were not interviewable for indicating hot water temperatures.</p>	F0323	<p>F323 483.25(h) ACCIDENTS</p> <p>It is the practice of Rural Health Care to ensure that the resident's environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>I. LPN #2 has been re-educated regarding disposing of sharps including needles at the point of care delivery. Resident #16 was not adversely affected by the transfer to w/c; CNA # 6 and #11 were re-educated regarding safe resident transfer to include locking the w/c wheels. The water temps have been corrected.</p> <p>II. All residents have the potential to be affected.</p> <p>III. Licensed personnel have been re-educated on the facility policy</p>	02/10/2012			

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	<p>Findings include:</p> <p>A1. During a medication administration observation on 1/10/12 at 11:07 A.M., LPN #2 injected Resident # 9 with 1 ml of Haloperidol and afterwards walked out of room and into the hallway with an exposed filtration needle (appearing to be approximately 3 inches long) on the syringe to be disposed in a sharps container.</p> <p>The administrator was interviewed on 1/12/12 at 9:42 A.M. and indicated that it was not appropriate to walk down the hallway with an unexposed needle and that "he would not have done that", and the facility policy was requested.</p> <p>During a medication observation on 1/12/12 at 10:05 A.M. LPN # 2 injected Res #6 with 0.75ml of Haloperidol and afterwards walked out of room and down the hallway with an exposed filtration needle (appearing to be approximately 3 inches long) to a sharps container on the side of the medication cart for disposal. At this time, LPN # 2 was interviewed and indicated that she couldn't pull up a cover on the filtration needle because they do not have covers, and she did not have a sharps container with her in the room for disposal of the needle.</p>		<p>regarding safe disposal of sharps including needles. Nursing personnel have been re-educated on safely transferring a resident from/to a wheelchair to ensure the wheels are locked. The maintenance director is monitoring water temps in the shower room as part of the daily maintenance rounds.</p> <p>IV. The DON or her designee is conducting quality improvement audits regarding resident safety. 2 nurses are being audited weekly for 30 days to ensure safe disposal of needles; this audit will then be conducted monthly for 6 months. CNAs are being monitored during routine resident care to ensure transfers are completed safely. 4 CNAs are being audited weekly for 30 days then monthly for 6 months. The Maintenance Director or designee is checking water temperature in the shower room daily for 30 days; then daily Monday-Friday ongoing. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>		

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	<p>The Facility Policy for Syringe and Needle Disposal, received 1/12/12 at 10:55 A.M., indicated syringes and needles were to be placed into puncture resistant containers immediately after use.</p> <p>B1. Resident #16's clinical record was reviewed on 1/9/2012 at 2:30 p.m. The record indicated diagnoses including, but not limited to, paraplegia. Resident #16's most recent RAI (Resident Assessment Insturment) assessment was completed on 12/28/2011. The assessment included, but was not limited to, the following information: range of motion limits: impairment on both sides for lower extremities, impairment on one side for upper extremities, and assist of two people with transfers.</p> <p>During observation on 1/12/2012 at 11:40 a.m., CNA #6 and CNA #11 assisted Resident #16 with transferring from the bed to the wheelchair, without first setting the brakes on the wheelchair. The wall located approximately one foot behind the wheelchair prevented the wheelchair from rolling backwards when the resident sat down.</p> <p>Interview with the DON on 1/12/2012 at 2:38 p.m., indicated her expectations for a safe transfer from bed to a wheelchair was to always tell the resident what was happening, use a gait belt, make sure the</p>						

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	<p>wheelchair is locked, and use the shortest distance possible.</p> <p>C1. During the environment tour on 1/11/12 at 11:20 a.m. with the Maintenance Director, the water temperatures were tested in the resident shower room. The sink in the shower room next to the shower stalls registered at 130 degrees Fahrenheit. The first shower stall water temperature registered at 123.3 degrees Fahrenheit.</p> <p>In an interview with the Maintenance Director on 1/11/12 at 11:30 a.m., the Maintenance Director indicated that safe water temperature in a resident area should be 100-120 degrees Fahrenheit.</p> <p>In an interview with the Activity Director on 1/10/12 at 3:15 p.m., she indicated all 11 residents participating in the group interview were interviewable, or 29 non-bedfast residents who were not interviewable.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						

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F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to keep residents free from unnecessary medication by not providing non-medicinal interventions prior to medication use, affecting 1 of 2 residents, reviewed for PRN (as needed) anti-anxiety medication, in a total sample of 11 (Resident # 38).</p> <p>Findings include:</p> <p>The clinical record for Resident #38 was reviewed on 1/9/12 at 11:30 a.m.</p> <p>The diagnoses for Resident #38 included, but were not limited to: schizophrenia,</p>	F0329	<p>F329 483.25(I) UNNECESSARY DRUGS</p> <p>-</p> <p>It is the practice of Rural Health Care to ensure that each resident's drug regimen is free from unnecessary drugs.</p> <p>I. Resident #38 had no negative effect from receiving the PRN medication in October 2011.</p>	02/10/2012	

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	<p>paranoia, dementia.</p> <p>The October 2011 MAR (Medication Administration Record) for Resident #38 indicated that Ativan (anti-anxiety medication) 1 mg (milligram) was given on 10/1/11 (no time indicated). On 10/28/11, Ativan 1 mg was given at 5:00 p.m. and then again 11:00 p.m. No non-medicinal interventions were indicated prior to Ativan administration on the dates and times listed.</p> <p>On two anxiety Comprehensive Care Plans dated 7/19/11 and 10/11/11, an intervention indicated that non intrusive techniques are to be utilized to help facilitate relaxation.</p> <p>In an interview with the DoN (Director of Nursing), on 1/12/12 at 10:25 a.m., she indicated that non-medicinal interventions are to be used prior to use of anti-anxiety medications. She also indicated that she no explanation why non-medicinal interventions were used prior to the use of Ativan on the above dates and times.</p> <p>3.1-48(a)(6)</p>		<p>II. All residents have the potential to be affected.</p> <p>III. Licensed nurses have ben re-educated regarding the importance of utilizing non-drug interventions to alleviate behavior concerns prior to administering any PRN medications. PRN psychoactive drug use will be reviewed during morning clinical meeting to further ensure appropriate interventions are documented. In addition, the facility conducts a monthly behavior management meeting. PRN psychoactive medications will also be reviewed during that meeting.</p> <p>IV. The DON or her designee is conducting quality improvement audits of psychoactive drug use. A random sample of 4 resident MAR will be reviewed weekly for 30 days; then monthly for 6 months. This audit will include checking the behavior documentation record to ensure non-drug methods are attempted prior to drug use. The pharmacy consultant will assist with review during monthly facility visits. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>		

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F0332 SS=E	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed receiving medications from a sample of 11 (Residents #12 and #38), and 3 of 10 residents (Residents #24, #20 and #17) from a supplemental sample of 13. Five errors in medication administration were observed during 40 opportunities for errors in medication administration resulting in a medication error rate of 12.5%.</p> <p>Findings include:</p> <p>1. During an observation of the medication pass on 1/10/12 at 12:30 P.M., LPN # 2 used a Fingerstick and Insulin Administration Form for Resident # 24 for the month of January 2012 to determine the results of the last blood sugar taken and the amount of insulin to be given, according to a sliding scale located at the top of this form.</p> <p>LPN #2 indicated Resident # 24's blood sugar was taken at 10:50 A.M. by QMA # 8 on this date with a result of 293 (251-300 = 6 units) requiring 6 units of insulin be given according to the sliding</p>	F0332	<p>F332 483.25(m) MEDICATION ERRORS</p> <p>It is the practice of Rural Health Care to ensure that Residents are free of any significant medication errors.</p> <p>I. Resident #24 physician was notified of the error in insulin dosage. Resident #20 is receiving inhaler medication as per order; QMA #8 has been re-educated on inhaler administration; Resident #17 is receiving the medication at the correct time; QMA #8 was re-educated regarding following med pass times; Resident #12 is receiving the correct dose of medication; LPN #9 has been re-educated on measuring liquid medications; Resident #38 is receiving medications at the correct time; LPN #2 has been re-educated regarding following med pass times.</p> <p>II. All residents have the potential to be affected.</p>	02/10/2012			

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	<p>scale listed.</p> <p>A physician's recap order dated 12/31/11 reviewed on 1/10/12 at 12:38 p.m., indicated for Resident # 24 to receive 12 units of Novolog insulin to be given (regularly scheduled) at lunch. LPN # 2 combined the order for 12 units to be given at lunch with the amount indicated for the sliding scale coverage of 293 (6 units), and at 12:35 P.M. LPN # 2 administered 18 units of Novolog subcutaneously to the resident's abdomen.</p> <p>Record review on 1/10/12 at 12:40 P.M., of physician's recap dated 12/31/11 showed a sliding scale for a blood sugar of 293 (251-300 = 4 units) indicating Resident # 24 was to receive 4 units of Novolog and a total of 16 units should have been given.</p> <p>LPN # 2 was interviewed on 1/10/12 at 12:45 P.M., and indicated the Fingerstick Form had an incorrect sliding scale and the resident should have received 16 units of Novolog instead of the 18 units administered. LPN # 2 prepared a Medication Error Report and documented that physician and family were notified of the error.</p> <p>2. On 1/10/12 at 5:16 P.M., Resident # 20 was observed receiving the medication</p>		<p>III. Licensed nurses and QMAs have been re-educated regarding the medication administration to include the right time and right amount and to follow manufactures guidelines. Nurses and QMAs have had competency checks performed regarding medication administration.</p> <p>IV. The DON or her designee is conducting quality improvement audits regarding medication administration. A random sample of 4 nurses or QMAs are checked weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>		

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	<p>Pro Air HFA through an inhaler. QMA # 8 put the inhaler to the resident's mouth and administered 2 consecutive puffs of this medicine and left to return to the med cart.</p> <p>Review of manufacturer's instructions listed for ProAir HFA indicated as follows: "Take the inhaler out of your mouth and close your mouth. Hold your breath as long as you can, up to 10 seconds, then breathe normally. If you doctor has prescribed more sprays, wait 1 minute and shake the inhaler again. Repeat steps."</p> <p>Physician's recap orders, reviewed on 1/10/12 at 5:45 P.M., dated 1/1/12, indicated ProAir HFA, 90mcg, was to be given with 2 puffs 3 times a day.</p> <p>QMA # 8 was interviewed on 1/10/12 at 6:00 P.M. and indicated she gave the puffs with the inhaler consecutively because "the resident likes it that way." The QMA provided no education to the resident on the effective/correct way to use an inhaler.</p> <p>3. On 1/10/12 at 5:18 P.M. Resident # 17 was observed receiving 3 capsules of Zonsamide by QMA # 8. The medication card indicated the medication was to be administered at 9:00 A.M. and 9:00 P.M.</p>			
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	<p>Physician recap, dated 1/1/12, was reviewed immediately after medication administration and indicated Zonsamide, 300mg, (3 capsules) be given by mouth 2 times a day at 9:00 A.M. and 9:00 P.M.</p> <p>The MAR for 1/10/12 was reviewed and indicated this medication had been given at the morning medication pass at 9:00 A.M.</p> <p>During an interview on 1/10/12 at 6:10 P.M., QMA # 8 stated, "The resident likes to get this medication early," and she gives it at the early evening medication pass. No instruction was given to resident about medications administered too early.</p> <p>4. On 1/11/12 at 10:00 A.M. the medication Calcitrol was observed being prepared for Resident # 12. The container indicated that 0.13 mcg (0.13 ml) was to be given 2 times a day. LPN # 9 drew up this medication in the liquid form for administration into a g-tube using a small syringe with a scale of ml's to the hundreds (0.10 - 0.20) on one side and a drop scale on the other side. The medication was drawn up by LPN # 9 using the ml side up to the 0.10 mark, and then the gtt (drops) side was used to determine the 0.13 amount resulting in 0.16 ml as the total amount measured to</p>			
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	<p>be given.</p> <p>LPN # 9 was stopped before the incorrect amount of Calcitrol was given. LPN # 9 was interviewed at this time, reevaluated the amount in the syringe, and indicated the amount drawn up for administration was incorrect.</p> <p>Physician's recap, dated 1/1/12, was reviewed immediately after medication administration and indicated Calcitrol 0.13 mcg (0.13 ml) be given 2 times a day.</p> <p>5. On 1/12/12 Resident # 38 was observed receiving the medication Furosemide at 11:45 A.M. by LPN # 2. The packaging indicated that this medication was to be given at 9:00 A.M. and 2:00 P.M.</p> <p>The physician's recap, dated 1/1/12, was reviewed immediately after medication administration and ordered Furosemide 40 mg, (1 tab given by mouth) 2 times a day and 9:00 A.M. and 2:00 P.M.</p> <p>During an interview at 12:50 P.M. on 1/12/12, LPN # 2 indicated the Furosemide was to be given at 9:00 A.M. and 2:00 P.M. She indicated she gave the first dose at 8:30 AM. but stated the second dose "was given earlier because</p>						

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NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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	<p>the resident likes to get this medicine at this time." There was no instruction given to the resident at this time on the importance of taking medication as ordered.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			
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F0333 SS=D	<p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents were free of significant medication errors for 2 of 2 residents reviewed for significant medication errors in a sample of 11 residents (Residents # 24 and 12).</p> <p>Findings include:</p> <p>1. During an observation of the medication pass with on 1/10/12 at 12:30 P.M., LPN # 2 used a Fingerstick and Insulin Administration Form for Resident # 24 for the month of January 2012 to determine the results of the last blood sugar taken and the amount of insulin to be given, according to a sliding scale located at the top of this form.</p> <p>LPN# 2 indicated Resident # 24's blood sugar was taken at 10:50 A.M. by QMA # 8 on this date with a result of 293 (251-300 = 6 units) requiring 6 units of insulin be given according to the sliding scale listed.</p> <p>A physician's recap order, dated 1/1/12, indicated Resident # 24 was to receive 12 units of Novolog insulin to be given (regularly scheduled) at lunch. LPN # 2 combined the order for 12 units to be</p>	F0333	<p>F333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>It is the practice of Rural Health Care to ensure that residents are free of any significant medication errors.</p> <p>I. Resident #24 physician was notified of the error in insulin dosage. Resident #12 is receiving the correct dose of medication; LPN #9 has been re-educated on measuring liquid medications.</p> <p>II. All residents have the potential to be affected.</p> <p>III. Licensed nurses and QMAs have been re-educated regarding the medication administration to include the right time and right amount and to follow manufactures guidelines. Nurses and QMAs have had competency checks performed regarding medication administration.</p>	02/10/2012			

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	<p>given at lunch with the amount indicated for the sliding scale coverage of 293 (6 units), and at 12:35 P.M. LPN # 2 administered 18 units of Novolog subcutaneously to the resident's abdomen.</p> <p>Record review on 1/10/12 at 12:40 P.M. of physician's recap, dated 12/30/11, indicated a sliding scale for a blood sugar of 293 (251-300 = 4 units), indicating Resident # 24 was to receive 4 units of Novolog, and a total of 16 units should have been given.</p> <p>LPN # 2 was interviewed on 1/10/12 at 12:45 P.M. and indicated the Fingerstick Form had an incorrect sliding scale and the resident should have received 16 units of Novolog instead of the 18 units administered. LPN # 2 prepared a Medication Error Report and documented that physician and family were notified of the error.</p> <p>2. On 1/11/12 at 10:00 A.M. the medication Calcitriol was observed being prepared for Resident # 12. The container indicated that 0.13 mcg (0.13 ml) was to be given 2 times a day. LPN # 9 drew up this medication in the liquid form for administration into a g-tube using a small syringe with a scale of ml's to the hundreds (0.10 - 0.20) on one side and a drop scale on the other side. The</p>		<p>IV. The DON or her designee is conducting quality improvement audits regarding medication administration. A random sample of 4 nurses or QMAs are checked weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>		

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	<p>medication was drawn up by LPN # 9 using the ml side up to the 0.10 mark and then the gtt side was used to determine the 0.13 amount resulting in 0.16 ml as the total amount measured to be given.</p> <p>LPN # 9 was stopped before the incorrect amount was given. LPN #9 was interviewed at this time, reevaluated the amount in the syringe, and agreed that the amount drawn up for administration was incorrect.</p> <p>Review of Davis's Drug Guide, (2005 ed.) pg.1090 indicated Calcitriol's adverse reactions and side effects are seen primarily as manifestations of toxicity (hypercalcemia) due to fat solubility and storage in the liver.</p> <p>Physician's recap, dated 1/1/12, was reviewed and indicated Calcitriol 0.13 mcg (0.13 ml) be given 2 times a day.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>				

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to ensure a sanitary environment for serving food, with the potential to affect 39 of 41 residents during kitchen observation. The facility also failed to ensure staff did not touch ready to eat food with bare hands for 3 of 39 residents observed being served bread during a lunch observation. (Residents #28, #30, and #38)</p> <p>Findings include:</p> <p>1. On 1/9/2012 at 11:50 a. m., a ceiling fan located above the prep table in the kitchen was observed to have noticeable dust on the top and sides of the blades.</p> <p>Interview with the Dietary Manager on 1/10/2012 at 12:45 p.m., indicated the fan had been cleaned recently, exact date unknown, and it was never used due to the cord being too short to reach in order to turn it on.</p> <p>2. On 1/9/2012 at 10:00 a. m., kitchen flooring with chipped and missing floor tiles in multiple spots exposing black sub flooring was observed.</p>	F0371	<p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>It is the practice of Rural Health Care to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, and prepare, distribute, and serve food under sanitary conditions.</p> <p>I. The ceiling fan in the kitchen was cleaned. The facility is obtaining bids on replacing the kitchen flooring-the floor has been cleaned. Resident #28, #30, and #38 were not adversely affected.</p> <p>II. All residents have the potential to be affected.</p> <p>III. Dietary personnel have been re-educated regarding kitchen sanitation including cleaning the</p>	02/10/2012	

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	<p>Interview with the Dietary Manager on 1/10/2012 at 12:45 p. m., indicated the floors are swept and mopped at the end of every night and also professionally deep cleaned every week.</p> <p>Review of the weekly cleaning sheet record provided by the Dietary Manager on 1/10/2012 at 1:18 p.m., indicated the following were cleaned weekly: floor buffed by floor guy and ceiling fan.</p> <p>3. During a lunch observation on 1/9/12 at 12:10 p.m., the Dietary Manager pulled Resident #28's bread out of its packaging and placed butter on the bread without any gloves on.</p> <p>4. During a lunch observation on 1/9/12 at 12:15 p.m., CNA #1 pulled Resident #30's bread out of its packaging without any gloves on.</p>		<p>ceiling fan and floors. Dietary and nursing personnel have been inserviced regarding handwashing or glove use before touching resident food.</p> <p>IV. The Dietary Manager or her designee is conducting quality improvement audits regarding kitchen sanitation. This weekly audit includes checking the floor and the ceiling fan for cleanliness. In addition meal service will be audited to ensure handwashing or glove use before touching resident food. 3 meals a week will be monitored for 30 days; then monthly for 6 months. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary</p>		

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	<p>5. During a lunch observation on 1/9/12 at 12:16 p.m., the Dietary Manager pulled Resident #38's bread out of its packaging without any gloves on.</p> <p>During an interview with the ADoN (Assistant Director of Nursing), on 1/12/12 at 10:30 a.m., he indicated when serving food from packaging, staff is supposed to hold the edge of the packaging and let the food slide onto the resident's plate without touching the food, when staff is not wearing gloves.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				

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F0372 SS=F	<p>The facility must dispose of garbage and refuse properly.</p> <p>Based on observation and interview, the facility failed to properly contain refuse in dumpsters with closed side doors with the potential to affect 41 of 41 residents.</p> <p>Findings include:</p> <p>During an environment tour on 1/11/12 at 11:35 a.m., there was an observation of both facility dumpsters, that had refuse in each of them, with the side doors open on each dumpster.</p> <p>During an observation on 1/12/12 at 2:25 p.m., the facility dumpster on the left, had its side door open and there was food refuse in the dumpster.</p> <p>In an interview with the Maintenance Director, on 1/11/12 at 11:36 a.m., he indicated that all doors and lids are to be closed on both dumpsters at all times.</p> <p>In an interview with the Maintenance Director, on 1/12/12/at 2:26 p.m., he indicated that the side doors on the dumpsters are to be closed at all times.</p> <p>3.1-21(i)(5)</p>	F0372	<p>F372 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY It is the practice of Rural Health Care to dispose of garbage and refuse properly. I. No residents were identified. II. All residents have the potential to be affected. III. Facility personnel have been educated on keeping the dumpster lids closed. IV. The Maintenance Director or his designee is completing a quality improvement audit of the trash dumpsters to ensure the lids are closed. The audit will be completed 3 times a week at random times for 30 days; then monthly for 6 months. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary</p>	02/10/2012	

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure safety when liquid medicine was disposed in an open trash receptacle instead of in accordance with the facility's policy, for 1 of 1 resident (Resident #12) from the sample of 11 whose liquid medication was observed being discarded.</p> <p>Findings include:</p> <p>On 1/11/12 at 10:00 A.M., LPN #9 measured liquid medications of Resident # 12, before the measurements could be observed, and disposed of them in the open trash receptacle on the side of the medication cart located in the hallway, where confused residents were walking</p>	F0425	<p>F425 483.60(a)(b) PHARMACEUTICAL SVC, ACCURATE PROCEDURES, RPH</p> <p>It is the practice of Rural Health Care to provide routine and emergency drugs and biological to its residents; and to provide services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident.</p> <p>I. LPN #9 has been re-educated</p>	02/10/2012			

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	<p>and passing in wheel-chairs.</p> <p>During an interview with the Administrator on 1/12/12 at 9:42 A.M., he indicated liquid medications should be disposed in the hopper in the utility room and that he would provide the facility policy.</p> <p>The facility policy for Discontinued Medicines was received on 1/12/12 at 2:00 P.M. and indicated, "Liquids that cannot be placed in a sharps container can be flushed down the hopper</p> <p>3.1-25(o)</p>		<p>regarding the proper disposal of unused medications.</p> <p>II. All residents have the potential to be affected.</p> <p>III. Licensed nurses and QMAs have been re-educated on the facility policy regarding medication disposal. Additional systemic changes are being implemented through our quality improvement process as described in IV.</p> <p>IV. The DON or her designee is conducting quality improvement audits regarding medication administration. A random sample of 4 nurses or QMAs are checked weekly for 30 days; then every other week for 30 days; then monthly for 6 months. This audit will include checking to see that medications not taken will be disposed of properly. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary.</p>		

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F0441 SS=D	<p>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.</p> <p>(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.</p> <p>(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. (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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to utilize the infection control practice of handwashing in order to prevent the spread of infection</p>	F0441	F441 483.65 (a)(1) INFECTION CONTROL	02/10/2012			

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	<p>during a skin assessment for 1 of 1 resident observed for skin assessment in a sample of 11 residents. (Resident #12)</p> <p>Findings include:</p> <p>Resident #12's clinical record was reviewed on 1/9/2012 at 1:45 p. m. The record contained diagnoses that included but were not limited to, infantile cerebral palsy, and organic brain damage.</p> <p>Observation of Resident #12 on 1/12/2012 at 10:30 a. m. indicated LPN #2 performed a skin assessment without first washing her hands before donning gloves and touching the resident's bare skin.</p> <p>Interview with the Director of Nursing on 1/12/2012 at 3:35 p. m. indicated that her expectations for her staff is to always wash their hands before providing any resident care.</p> <p>3.1-18(l)</p>		<p>It is the practice of Rural Health Care to 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.</p> <p>I. Resident #12 was not adversely affected. LPN #2 was re-educated regarding handwashing during resident care.</p> <p>II. All residents have the potential to be affected.</p> <p>III. Nursing personnel have been re-educated on the importance of handwashing before and after resident care and treatment. Additional systemic changes are being implemented through our quality improvement process as described in IV.</p> <p>IV. The DON or her designee is conducting quality improvement audits on handwashing. A random sample of 4 nursing personnel are being checked weekly for 30 days; then monthly</p>		

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			for 6 months to ensure handwashing is completed before and after resident care. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary		

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F0465 SS=F	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a clean and comfortable, environment due to stained and worn furniture, missing shower room tiles, and smeared windows.</p> <p>Additionally, the facility failed to provide comfortable temperatures and an environment free of smoke smell during smoke breaks, with the potential to affect 41 of 41 residents.</p> <p>1. During the environment tour on 1/11/12 at 10:40 a.m., two armchairs were observed in the front entrance to have multiple stains on the fabric and the legs on both chairs had chips in them and a worn appearance. On both chairs, there were hand sized brown stains on the front of both armrests on each chair. On both chairs, there were head sized brown stains in the middle to top of the chair fronts.</p> <p>In an interview with the Maintenance Director on 1/11/12 at 10:41 a.m., he indicated furniture is replaced as needed and that both of the armchairs needed to be replaced.</p>	F0465	<p>F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT It is the practice of Rural Health Care to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>I. The armchairs at the front entrance were removed and replaced during the survey. Bids are being obtained to repair the tiles and entrance to the shower room. The exit door to the resident smoking area is kept closed at all times. Resident #21 was relocated to another room at his request. The windows in room 3 and 23 were cleaned.</p> <p>II. All residents have the potential to be affected. III. Facility personnel have been re-educated on the importance of providing a clean comfortable environment. This inservice included the importance of keeping the exit door closed during resident smoke breaks to ensure smoke odor is contained and to prevent cold air from coming into the hallways. IV. The Administrator or his designee is conducting quality improvement rounds weekly for 30 days then monthly for 6 months to ensure that the furniture is clean and in good repair, that windows are kept clean, that smoke odor is contained and the hallways are</p>	02/10/2012			

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	<p>In an interview the DoN (Director of Nursing) on 1/12/12 at 10:25 a.m., she indicated that the entrance armchairs needed to be replaced.</p> <p>2. During an observation on the environment tour of the facility with the Maintenance Director on 1/11/12 at 11:19 a.m., the entrance to the resident shower room was observed to have several missing tiles along the entire entrance and there was a 1 and 1/2 inch gouge/crevice also along the entire entrance.</p> <p>3. During an observation on 1/9/12 at 11:35 a.m., the door leading to the patio where smoke breaks took place, was propped open till 11:45 a.m. There was a heavy odor of cigarette smoke in the facility hallway next to the patio, that contained residents' rooms, during the time that door was propped open. There was also a cold draft coming in from the opened patio door in the same hallway during the time the door was propped open.</p> <p>During an observation on 1/9/12 at 1:30 p.m., the door leading to the patio where smoke breaks took place, was propped open till 1:55 p.m. There was a heavy odor of cigarette smoke in the facility hallway next to the patio, that contained residents' rooms, during the time that door</p>		free from cold drafts. Results of all audits are reported to the QA Committee monthly for additional recommendations as necessary				

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	<p>was propped open. There was also a cold draft coming in from the opened patio door in the same hallway during the time the door was propped open.</p> <p>Resident #21, whose room was located across from the patio door, was interviewed on 1/9/12 at 2:10 p.m. The resident indicated he gets cold when the door is propped open during smoke breaks.</p> <p>In another interview with Resident #21, on 1/11/12 at 9:20 a.m., the resident indicated the cigarette smoke smell bothers him while the door is propped open during smoke breaks.</p> <p>4. During an observation of room #3 during the environment tour on 1/11/12 at 11:00 a.m., both window panes had hand sized smears in the middle of each window pane and cobwebs were observed on the left window pane.</p> <p>During an observation of room #23 during the environment tour on 1/11/12 at 11:15 a.m., there was a fist sized smear in the middle of right window pane.</p> <p>In an interview with the Maintenance Director on 1/11/12 at 11:01 a.m. and 11:16 a.m., he indicated that the windows in room #3 and #23 needed to be cleaned.</p>			
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F0469 SS=F	<p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview, and record review the facility failed to ensure an effective pest control program, due to the observation of mice droppings and gnats, with potential to affect 41 of 41 residents.</p> <p>Findings include:</p> <p>1. During an observation on 1/10/12 at 4:15 p.m., in the dining room, there was mice droppings in the corner underneath the television.</p> <p>During an observation on 1/11/12 at 11:30 a.m., in the dining room, there was mice droppings near the wall, under the window closest to the television.</p> <p>During an interview with the Maintenance Director on 1/10/12 at 4:16 p.m., he indicated that mice droppings were what he also observed in the dining room under the television. He also indicated that a pest control company was just in the building earlier that week on 1/9/12 and did a "clean-out and service" for mice. The Maintenance Director indicated that a pest control service comes weekly.</p> <p>During an interview with the Maintenance Director on 1/11/12 at 11:31 a.m., he</p>	F0469	<p>F469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM It is the practice of Rural Health Care to maintain an effective pest control program. I. Residents #31 & #41 have not voiced any additional reports of mice. II. All residents have the potential to be affected. III. The facility has contacted the pest control company to utilize a chemical that will help eliminate gnats and mice. The pest control company is providing service weekly. The Administrator or his designee will meet with the pest control company's representative to discuss whether the product used thevious week was helpful with reducing and eliminating knats and mice. IV. The Administrator or his designee is completing quality improvement audits of pest control with particular attention to mice and gnats. These audits will be completed weekly for 30 days, then monthly for 6 months. Results of all audits are being reviewed monthly by the facility's quality assurance committee for additional recommendations as necessary.</p>	02/10/2012			

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	<p>indicated that mice droppings were also observed in the dining room under the window closest to the television.</p> <p>During the group interview on 1/10/12 at 3:45 p.m., Resident #31, indicated he saw a mouse the previous week under the television in the dining room. Also, in the group interview, Resident #41 indicated she saw a mouse 3 weeks earlier under the television in the dining room.</p> <p>In a record review of January 2012, November 2011, and December 2011 receipts of a pest control service, indicated the service was in the building for the following dates for "clean-out and service" for mice: 1/9/12, no time indicated 1/3/12, no time indicated 12/27/11, no time indicated 12/19/11, no time indicated 12/12/11, no time indicated 12/5/11, no time indicated 11/28/11, no time indicated 11/21/11, no time indicated 11/7/11, no time indicated.</p> <p>2. At the following dates and times, gnats were seen flying around the facility: 1/10/12 at 10:50 a.m., near room #21 1/10/12 at 12:25 p.m., near the nurse's station 1/10/12 at 3:45 p.m., in the dining room</p>						

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	<p>1/11/12 at 9:45 a.m., near room #21 1/11/12 at 11:45 a.m., near the nurse's station 1/11/12 at 5:00 p.m., in room #19 1/12/12 at 2:45 p.m. in room #20</p> <p>In an interview with DoN (Director of Nursing) on 1/12/12 at 10:32 a.m., she indicated any time there is pest control issue brought to attention, their pest control service is to be called immediately for service.</p> <p>3.1-19(f)(4)</p>						