STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON NURSING AND REHABILITATION CENTER	1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620

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F000000	This visit was for a Recertification and State Licensure survey. Survey Dates: June 24, 25, 26, 27, 28, July 1, 2, 2013 Facility Number: 000234 Provider Number: 155342 AIM Number: 100273490 Survey Team: Barbara Fowler, RN TC Amy Wininger, RN Diane Hancock RN: 6/24/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13 Census Bed Type: SNF: 7 SNF/NF: 57 Total: 64 Census Payor Type: Medicare: 10 Medicaid: 34 Other: 20 Total: 64 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2	F000000	The preparation and/or execution of this plan of correction does not constitute agreement or admission by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality review completed on July 9, 2013, by Jodi Meyer, RN			

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F000156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on observation, record review, and interview, the facility failed to display the appropriate Medicare and Medicaid posting and failed to ensure resident rights were periodically reviewed with the residents. This had the potential to affect 64 of 64 residents in the facility. Findings include: 1. During a tour of the facility on 6/26/13 at 10:25 a.m., no posting for Medicare or Medicaid was observed. During a tour of the facility on 6/27/13 at 1:00 p.m., no posting for Medicare or Medicaid was observed. During an interview on 6/28/13 at 1:30 p.m., the Administrator (Adm) indicated she did not know which document needed to be posted. During an interview on 6/28/13 at 11:45 a.m., the Business Office Manager (BOM) indicated she did not know what the proper document was but she would locate the document and post it. During an interview on 6/28/13 at 1:15 p.m., the BOM indicated she had	F000156	It is the policy of Mt Vernon Nursing and Rehab Center to provide and inform the resident both orally and in writing so that the resident understands how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such benefits.This information is part of the admission packet and has been available. Currently, this information has been framed and placed on the wall outside of the Business Manager's office so that all visitors, families and residents can access the information quickly.This posting will remain displayed and will be accounted for on each environmental tour. Weekly the Administrator will make note that the posting is still in full view by the Business Office Manager's office and will forward that documentation to the QA committee monthly x 6 months, with further recommendations as indicated.Resident council members will be educated on the rights of the individual in the nursing home setting each month during their meetings. The council will choose the right to be discussed during each meeting and this practice will continue. This information will be documented on the resident council minutes form and located in the binder kept in the Activities office. The LED/Administrator will	07/02/2013

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	spoke to another facility and located the proper documentation and had posted it in the front lobby. 2. During an interview with the Resident Council President on 6/25/13 at 1:00 p.m., the Resident Council President indicated resident rights were not discussed during their meetings and he did not know what his rights were. The resident council minutes were reviewed on 7/1/13 at 12:15 p.m. The minutes did not indicate any review of the resident rights from July, 2012, through June, 2013. During an interview with the Activity Director (AD) on 7/1/13 at 1:30 p.m., the AD indicated she attempts to review the resident rights in the resident council meetings every six months. She indicated she usually reviewed the resident rights with the resident on a 1 to 1 basis if they requested. During an with the Administrator (Adm) on 7/1/13 at 1:45 p.m., the Adm indicated she would speak with the resident council members at their meetings regarding the resident rights but did not recall when she spoke to the members.		audit monthly that this correction has been enforced to ensure that each resident is aware of their rights and can exercise their rights independently, if they so choose. The notes from the resident council meetings will be forwarded to the QA committee monthly for review and further recommendations as indicated, for 6 months.	

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	3.1-4(l)(1) 3.1-4(a)			

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F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure 3 of 10 residents reviewed for unnecessary medications was free of unnecessary medications, in that anti-psychotic medications were administered without monitoring of behaviors. (Resident #45, Resident #26, Resident #15) Findings include: 1. Resident #45 was observed on 06/25/13 at 10:15 a.m., sitting in a chair in the resident's room. Resident #45 was observed, at that time, to be experiencing no signs or symptoms of psychosis, mania, or behaviors. The clinical record of Resident #45 was reviewed on 06/26/13 at 2:47 p.m. The record indicated the diagnoses of Resident #45 included, but were not limited to, major depressive d/o (disorder) recurrent severe with psychotic features, and bipolar.	F000250	It is the policy of Mt Vernon Nursing and Rehab Center to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. Residents #45, #26 and #15 of the survey sample have been assessed to identify any new on-set behaviors and to assure that current identified behaviors are care planned with effective interventions. SSD will complete a one time, 100% medical record review to ensure that appropriate documentation is in place to monitor and ensure that residents are free of unnecessary medications. SSD will re-educate staff to determine what is a behavior and the appropriate documentation to ensure consistent communication. SSD/designee will communicate behavioral interventions to staff initially and will monitor behavior tracking reports daily as indicated. Nursing will document behaviors, interventions and effectiveness in the nurses' notes. The resident will be placed on the acute charting format. Nursing and SSD will monitor the behavior via the acute	08/01/2013

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	A Consultation Report dated 05/13/13 indicated Resident #45 had been admitted to a behavioral health facility for the following behavioral problems, "...increasing agitation, anxiety, tearfulness, yelling at other patient's [sic], name calling, repeating over and over again and upsetting. [Resident #45] has also became [sic] very aggressive." The most recent Quarterly MDS (Minimum Data Set Assessment) dated 05/24/13 indicated Resident #45 experienced mild cognitive impairment and exhibited no behaviors. The May 2013 Physician's Order Recap indicated orders dated 05/17/13 for, "Seroquel [an antipsychotic medication] 50 mg [milligrams] by mouth twice daily...Seroquel 150 mg by mouth at bedtime." The daily dose of Seroquel totaled 250 mg. A Physician's Telephone Order dated 06/27/13 at 6:15 p.m. indicated, "...DC [discontinue] Seroquel...Seroquel 100 mg by mouth three times daily." The daily dose of Seroquel totaled 300 mg.		charting and will continue with recommendation from the Clinical Review Team. Ineffective interventions or new on-set behaviors that have the potential to affect the psychosocial well being of the residents will be referred to the attending MD and/or Psychiatric services for review and assessment. Upon receiving recommendation of initiation of a new psychoactive medication, reduction or increase of a current psychoactive medication dosage for the resident, the MD will be notified no less than q shift during MD business hours for approval or denial. Upon initiation of psychoactive medication the Clinical Team will develop the medication reduction plan r/t to effectiveness of interventions to ensure the residents are free of unnecessary drugs.SSD/designee will document as indicated in the residents' charts and will monitor behavior tracking in the CareTracker daily on-going as indicated. SSD/Nursing will monitor behaviors, interventions and effectiveness in the nurses notes, and the MAR's daily as indicated. The careplan will be updated in Clinical Review as indicated. Monthly, identified residents receiving psychoactive medications will be reviewed in the Behavioral Review meeting with recommendations forwarded to the attending MD. SSD will	

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	During an interview on 06/28/13 at 11:00 a.m. the SSD (Social Service Designee) indicated the order to revise the Seroquel was received from the Psychiatrist, had been sent to the attending physician, and the attending physician had not approved the Seroquel revision. The Social Service Progress Notes from 04/26/13 through 06/16/13 indicated Resident #45 experienced no behaviors. A care plan dated 05/24/13 for behavioral symptoms of curses, yells...hits, spits included, but was not limited to, the following interventions "medication administration, validation...provide one to one attendant as needed..." The care plan lacked any documentation related to paranoia, crying or bullying. A CNA Assignment Sheet dated 06/25/13 lacked any documentation of interventions to manage behaviors. A Behavior Symptoms Detail Report indicated Resident #45 experienced no "signs of being manic such as extreme agitation and anger" from 05/13/13 through 06/27/13. The report lacked any documentation r/t psychosis or other behaviors.		provide behavior tracking reports from Caretracker for review by the Clinical Team 5 days per week for 4 weeks; 2 days per week for 4 weeks; and as indicated thereafter. Information will be presented to the QA committee monthly, for 6 months for review with updates as indicated.	

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	During an interview on 06/28/13 at 10:05 a.m., the SSD indicated the signs of mania on the Behavior Symptoms Detail Report were not specific to Resident #45 and were generic for anyone with a diagnosis of bipolar. The SSD further indicated, at that time, the behaviors of Resident #45 included, but were not limited to, paranoia, bullying, and stated, "..major depression...really bad, gets psychosis..." The Nurses notes from 05/17/13 through 06/28/13 indicated Resident #45 experienced one episode of crying that was easily re-directed. The notes lacked any documentation of paranoia, bullying, major depression, or psychosis. During an interview on 06/28/13 at 10:40 a.m., the SSD indicated there was no formal monitoring plan of specific identified behaviors for Resident #45. The SSD further indicated, at that time, the behaviors of Resident #45 were easily re-directed if interventions were implemented quickly. 2. Resident #26 was observed on 06/24/13 at 10:15 a.m., lying in bed.			

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	Resident #73 was observed, at that time, to be experiencing no signs or symptoms of anxiety or psychosis. The clinical record of Resident #26 was reviewed on 06/26/13 at 10:34 a.m. The record indicated the diagnoses of Resident #26 included, but were not limited to, Dementia. The most recent Quarterly MDS (Minimum Data Set Assessment) dated 05/08/13 indicated Resident #26 experienced severe cognitive impairment and no behaviors. A Nurse's note, dated 05/16/13 at 3:00 p.m. indicated, "Res [resident] awakes aggressive [sic] behavior toward staff, hitting, spitting grabbing equipment. One on one attempt et unsuccessful. Res states what [Resident #26] wants et [and] nurse attempts need et becomes more agitated. Res continues aggressive behavior. Nurse notifies MD [physician] on call new order received...Res. daughter called able to visit et behaviors calmed with success..." The nursing notes lacked any further documentation until 05/22/13 at 8:00 a.m., which indicated Resident #26 was "...very confused...".			

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	A Physician's Telephone Order dated 05/16/13 at 4:30 p.m., indicated a new order was received for, "Risperdal [an anti-psychotic medication] 2 mg by mouth three times daily..." The May 2013 MAR (Medication Administration Record) indicated Risperdal 2 mg began to be administered on May 18.2013. A Physician's Telephone Order dated 05/28/13 indicated the Risperdal was revised to 2 mg by mouth daily. The Nurse's notes lacked any documentation from 05/22/13 at 8:00 a.m. through 05/28/13 at 1:20 p.m. r/t monitoring the Risperdal or the behaviors. A Nurse's noted dated 05/29/13 at 8:00 a.m. indicated Resident #26 was "...pleasant and cooperative with staff. will continue to monitor." A Nurse's note dated 05/30/13 at 3:00 p.m. indicated, "Res having noted behavior while in shower assistance per nurse given to complete shower. Res struck staff, yelling out, cursing ..." The Nurse's notes lacked any further documentation until 06/05/13 at 8:00 a.m. which indicated,			

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	"...Resident very confused..." A Physician's Telephone Order dated 06/08/13 at 12:15 p.m. indicated the Risperdal was increased to 2 mg by mouth twice daily. The Target Behavior Summary with Details Report from 05/16/13 through 06/08/13 were reviewed and indicated, Resident #26 experienced one episode of becoming aggressive, hitting and yelling staff on 05/24/13. The report lacked any documentation related to episodes of behaviors to indicate a dose increase was needed. 3. Resident #15 was observed on 6/24/13 at 9:45 a.m., to be sleeping in bed. The clinical record of Resident #15 was reviewed on 6/26/13 at 10:48 a.m. Resident #15 had a diagnoses including, but not limited to, Parkinson's disease, mood disorder, depression, and dementia. Resident #15 had a physician's order, dated 6/24/13, Resident #15 had an order, dated 6/24/13, for Risperdal 0.5 mg (milligram) at HS (hour of sleep) for "flight of ideas."			

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	The quarterly Minimum Data Set (MDS), dated 5/2/13. indicated the resident did not have any behaviors. The significant change MDS, dated 3/12/13, indicated the resident had delusions. A care plan, dated 6/26/13, identified a problem of psychotropic drug use, which included, but was not limited to, the following interventions: Monitor side effects Monitor for drug related cognitive/behavioral impairment Monitor for drug-related discomfort Non-drug interventions A nursing Progress Note, dated 3/23/13 at 3:00 a.m., indicated Resident #15 was alert with confusion. The note indicated Resident #15 was talking about things her husband was telling her. The notes lacked any documentation of monitoring of the resident's behaviors. A nursing Progress Note, dated 4/29/13 at 8:00 a.m., indicated Resident #15 was talking about dogs and cats. The notes lacked any documentation for monitoring of the resident's behaviors. A nursing Progress Note on 5/8/13 at			

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	8:00 a.m., indicated Resident #15 was confused to facts. The nurse indicated the resident told stories and jokes and had indicated she had watched movies all day the day before in her mind. The notes lacked any documentation for monitoring or interventions. A nursing Progress Note, dated 6/7/13 at 9:00 p.m., indicated Resident #15 reverts to the past at times and thinks she is directing plays. The note indicated Resident #15 had asked the nurse if the nurse had seen her husband. No interventions or monitoring was documented. A Social Service Progress Note, dated 4/4/13, indicated the resident had two (2) delusions in March, 2013. A Social Service Progress Note, dated 5/2/13, indicated the resident had no delusions in April, 2013, and no hallucinations. A Social Service Progress Note, dated 6/19/13, indicated Resident #15 had two (2) delusions in June, 2013, and no hallucinations. An interview with the SSD (Social Services Director) on 6/27/13 at 2:49			

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	p.m., indicated the resident is monitored by nursing for interventions regarding confusion or behaviors, and after residents are placed on psychotropic medications. An interview with the ADoN (Assistant Director of Nursing) on 6/27/13 at 1:56 p.m., indicated if a resident has behavior changes, the resident is listed on the resident critical charting form and the nurses are to document in the nurse's notes regarding the issue. During an interview with the SSD on 7/2/13 at 8:15 a.m., there was no formal monitoring plan for psychotropic medications and behaviors. 3.1-34(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure the care plan was followed for 1 of 40 residents whose care plans were reviewed in stage 2, in that 1 resident did not have delirium ruled out prior to starting an psychotropic medication. (Resident #15) Findings include: Resident #15 was observed on 6/24/13 at 9:45 a.m., to be sleeping in bed. Resident #15 was observed on 6/25/13 at 10:00 a.m. to be up in a wheelchair in the hall. The resident was observed to have a dressing above her right eye and a bruise on her right forehead and around the outer right eye. The resident was observed to have a bruise on the back of her right hand and had a dressing on it. When interviewed, the resident indicated she had fallen while trying to get out of her wheelchair yesterday.	F000282	It is the policy of Mt Vernon Nursing and Rehab Center to ensure care was provided by qualified persons in accordance with each residents' written plan of care. The SSD/CRC will complete a one time 100% audit to assure follow through from MDS to care plan to service provision related to diagnosis and behavior intervention prior to starting a psychotropic medication. Re-educate the CRC and SSD to review MDS prior to completion to assure coordination of monitoring services needed and will be presented to the Behavior Review Team.An audit of ongoing MDS assessments to identify further residents will be completed by SSD and CRC and presented to Clinical Review for recommendations weekly, as indicated. Weekly, the Clinical Review Team convenes to assess the coordination of the services specific to the careplan and each discipline amends the careplan as indicated. The results will be forwarded to QA committee meeting monthly and forwarded for 6 months with further recommendations as indicated.	08/01/2013

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	The clinical record of Resident #15 was reviewed on 6/26/13 at 10:48 a.m. The record indicated Resident #15 had diagnoses which included, but were not limited to, mood disorder and dementia. Resident #15 had an order for Risperdal, dated 6/24/13, for a diagnosis of "flight of ideas." The quarterly Minimum Data Set (MDS), dated 5/2/13. indicated the resident did not have any behaviors. The significant change MDS, dated 3/12/13, indicated the resident had delusions. A care plan, dated 6/19/13, for psychosocial well-being included, but was not limited to the following interventions: "or safety risk, dated 6/19/13, included bur were no limited to, the following: "Rule out delirium" The record lacked any documentation that delirium was ruled out. During an interview on 6/27/13 at 2:49 p.m., SSD (Social Services Director) indicated the resident was monitored by nursing for interventions regarding confusion, behaviors, and after residents are placed on			

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	psychotropic medications. The SSD further indicated there was no documentation indicating delirium had been ruled out. 3.1-35(g)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to provide monitoring in 1 of 2 residents reviewed for death, in that a resident, with diabetes, bilateral "weeping" arms, a Foley catheter, and nasal oxygen, expired with no evidence of monitoring for more than 18 hours prior to the death. (Resident #30) Findings include: The clinical record of Resident #30 was reviewed on 6/26/13 at 1:55 p.m. Resident #30 had diagnoses including, but not limited to, respiratory failure and tracheostomy, and diabetes mellitus. The clinical record of Resident #30 indicated the resident had expired on 3/4/13 at 3:10 a.m. The clinical record lacked any documentation from 3/3/13 at 8:45 a.m. until the resident expired at 3:10 a.m. on 3/4/13.	F000309	It is the policy of Mt Vernon Nursing and Rehab Center to attain and maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Nursing was re-educated on documentation policy and procedure, assessment and care management of the resident. Nurses were re-educated for all charting requirements related to type and frequency of documentation in nursing notes. Nursing staff were re-educated on continual, consistent assessment of the resident to ensure the optimal coordination of care, from admission to discharge.Nursing Administration/Medical Records will review 2 random charts 5/7 days X 2 weeks; weekly X 4 weeks and monthly X 4 for appropriate documentation follow through of care. Recommendations will be forwarded to the QA committee monthly for 4 months.	08/01/2013

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	The Progress Notes, dated 3/3/13 at 8:45 a.m., indicated Resident #30 had bilateral upper and lower extremity edema with "weeping" of the left forearm and had a dressing covering the arm. The progress note indicated the resident received nasal oxygen (02) continuously and received insulin. The progress note further indicated Resident #30 received Lasix (an antihypertensive medication), had a urinary catheter in place, and had been on a fluid restriction. The Progress Notes, dated 3/4/13 at 3:10 a.m., indicated the vital signs of Resident #30 ceased to exist. The clinical record lacked any indication regarding the status of Resident #30's condition for eighteen (18) hours and twenty-five (25) minutes. During an interview on 6/27/13 at 4:42 p.m., the DoN (Director of Nursing) indicated Resident #30 was supposed to return home the following week. The DoN indicated a staff member had spoke to her the evening prior to Resident #30's death and indicated the resident was in his w/c (wheelchair) in the hall. The DoN indicated Resident #30 had propelled himself in his w/c and had been			

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	laughing with the staff. The DoN indicated Resident #30 was found deceased during a bed check. Interview with the DoN (Director of Nursing) on 6/28/13 at 8:35 a.m., the nurse probably should have documented about Resident #30's condition the evening prior to his death. 3.1-37(a)			

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F000329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. Based on observation, interview, and record review, the facility failed to ensure 4 of 10 residents reviewed for unnecessary medications were free of unnecessary medications, in that antipsychotic medications were administered without monitoring and indications for use . (Resident #68, Resident #45, Resident #26, Resident #15) Findings include:	F000329	It is the policy of the Mt Vernon Nursing and Rehab Center to adequately monitor for unnecessary medications via levels monitoring and potential adverse consequences. A one time 100% audit of residents was completed to identify residents prescribed psychotropic medications with no GDR scheduled upon initiation of medication and corrections were made. Acute charting was initiated. Nurses were re-educated to assure all psychotropic medication orders	08/01/2013

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	1. Resident #68 was observed on 6/26/13 at 8:45 a.m. in bed asleep. She was observed on 6/26/13 at 10:20 a.m. in the hallway outside her room in a wheelchair. She indicated she was short of breath and they had woke her up earlier for a breathing treatment. Interview with LPN #1, at that time, indicated the resident had her breathing treatment that morning but often did not remember. At 11:45 a.m. on 6/26/13, LPN #1 was observed to prepare to give Resident #68 a breathing treatment. The resident was forgetful, but followed requests without difficulty. Resident #68's clinical record was reviewed on 6/26/13 at 10:25 a.m. The resident was admitted to the facility on 2/1/13 with diagnoses including, but not limited to, chronic airway obstruction and senile dementia. She was admitted following a hospital stay, but had previously lived with sisters who cared for her. Resident #68's admission Minimum Data Set (MDS) assessment, dated 2/8/13, indicated no behaviors. The quarterly MDS, dated 4/3/13, indicated no behaviors. The quarterly		were reviewed for consistent follow through and/or involving the oversight of the Medical Director as well as the Pharmacy Representative. DON/SSD to monitor all new psychotropic medication orders to assure documentation warrants specific medication with oversight by the Behavioral Review Team. Acute charting will continue for the resident until removed by the Clinical Review Team d/t behaviors are managed with interventions in place. Modifications will be made on the care plan.Nursing Administration/SSD will monitor the acute charting format and ongoing report forms 5/7 days x 2 weeks; then weekly x 4; then monthly x 2. Recommendations will be forwarded to the QA committee monthly for 6 months with follow through as indicated.	

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	MDS, dated 5/12/13 indicated no behaviors. The Quarterly Care Plan Review summary, dated 5/12/13, indicated no behaviors and no mood issues. Physician's orders, since 2/2/13, included, but were not limited to, Risperidone (antipsychotic medication) 0.25 milligrams one tablet by mouth at bedtime. The resident's care plan for psychotropic drug use, initiated 2/27/13 and reviewed 5/12/13, included, but was not limited to, the following: Risperdal (risperidone) as ordered Diagnosis dementia with psychosis Agitation, wandering Interventions included, but were not limited to, the following: Monitor side effects Monitor drug related cognitive/behavioral impairment Monitor drug-related discomfort Non-drug interventions Pharmacy reviews indicated the following: 2/21/13, Risperidone with no behaviors documented, recommended discontinuing			

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	Risperdal The physician responded, "No...was just transferred here...daughter upset with this..." 5/17/13, recommended again to discontinue Risperdal in the absence of behaviors. The physician responded, "NO." A physician notification was documented on 5/22/13, indicating, "...Dtr [daughter] okay with d/c [discontinuing] risperdal per pharm rec. [recommendation] if it can be d/c'd after she returns...concerned res [resident] may have behavior while out of town..." The physician responded, "Not d/c." Social Service progress notes, dated 2/27/13, 4/3/13, and 5/12/13, indicated the resident was on Risperdal 0.25 milligrams with no GDR (gradual dose reduction) in the past quarter. All three notes indicated the resident was having no behaviors. LPN #1 was interviewed on 6/27/13 at 8:58 a.m. She indicated the resident never had behaviors on the day shift. She indicated the resident was just confused. There might be behaviors documented by the CNAs on other shifts. When queried about the Risperdal, she indicated there should			

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	be a diagnosis on the diagnosis list. Reviewed diagnosis list and it included but was not limited to, the following: chronic obstructive pulmonary disease, arthritis, dementia, osteopenia, vitamin D deficiency, hypothyroid, peripheral vascular disease, hypertension, general debility, dementia with psychosis. The resident's family member was interviewed at 9:45 a.m. on 6/27/13. She indicated the resident had not always been on Risperdal. She indicated the resident did have anxiety when she had trouble breathing, and anxiety attacks. The Social Service Designee (SSD) was interviewed on 6/27/13 at 9:45 a.m. She indicated the resident's physician would not discontinue the Risperdal. She indicated the resident was seeing a psychiatrist on that date (6/27/13) to see about medication reduction. There was no indication why the resident had not seen a psychiatrist earlier, or considered for dose reduction earlier. The medication use was reviewed with the Director of Nurses (DoN) on 6/28/13 at 10:00 a.m. She indicated she would need to review the record.			

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	At 10:20 a.m., she provided a discharge summary report and progress note from the resident's hospital stay. The progress note, dated 1/31/13 at 1:00 p.m. indicated the resident had "[increased] confusion...[increased] agitation and confusion during day...P) [plan] add Risperdal at HS [hour of sleep]."			
	2. Resident #45 was observed on 06/25/13 at 10:15 a.m., sitting in a chair in the resident's room. Resident #45 was observed, at that time, to be experiencing no signs or symptoms of psychosis, mania, or behaviors. The clinical record of Resident #45 was reviewed on 06/26/13 at 2:47 p.m. The record indicated the diagnoses of Resident #45 included, but were not limited to, major depressive d/o (disorder) recurrent severe with psychotic features, and bipolar. The most recent Quarterly MDS (Minimum Data Set Assessment) dated 05/24/13 indicated Resident			

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	#45 experienced mild cognitive impairment and exhibited no behaviors. The May 2013 Physician's Order Recap indicated orders dated 05/17/13 for, "Seroquel [an antipsychotic medication] 50 mg [milligrams] by mouth twice daily...Seroquel 150 mg by mouth at bedtime" The daily dose of Seroquel totaled 250 mg. A Physician's Telephone Order dated 06/27/13 at 6:15 p.m. indicated, "...DC [discontinue] Seroquel...Seroquel 100 mg by mouth three times daily" The daily dose of Seroquel totaled 300 mg. During an interview on 06/28/13 at 11:00 a.m. the SSD (Social Service Designee) indicated the order to revise the Seroquel was received from the Psychiatrist, had been sent to the attending physician and the attending physician had not approved the Seroquel revision. A Behavior Symptoms Detail Report indicated Resident #45 experienced no "signs of being manic such as extreme agitation and anger" from 05/13/13 through 06/27/13. The report lacked any documentation of			

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	monitoring r/t psychosis or other behaviors. During an interview on 06/28/13 at 10:05 a.m., the SSD indicated the signs of mania on the Behavior Symptoms Detail Report were not specific to Resident #45 and were generic for anyone with a diagnosis of bipolar. The SSD further indicated, at that time, the behaviors of Resident #45 included, but were not limited to, paranoia, bullying, and stated, "..major depression...really bad gets psychosis..." She further indicated, at that time, she did not have a system to monitor specific behaviors. The Nurses notes from 05/17/13 through 06/28/13 indicated Resident #45 experienced one episode of crying that was easily re-directed. The notes lacked any documentation of monitoring for paranoia, bullying, major depression, or psychosis. A care plan dated 05/24/13 for behavioral symptoms of curses, yells...hits, spits included, but was not limited to, the following interventions "medication administration, validation...provide one to one attendant as needed..." The care plan lacked any documentation related to paranoia, crying or bullying.			

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	3. Resident #26 was observed on 06/24/13 at 10:15 a.m., lying in bed. Resident #26 was observed, at that time, to be experiencing no signs or symptoms of anxiety or psychosis. The clinical record of Resident #26 was reviewed on 06/26/13 at 10:34 a.m. The record indicated the diagnoses of Resident #26 included, but were not limited to, Dementia. The most recent Quarterly MDS (Minimum Data Set Assessment) dated 05/08/13 indicated Resident #26 experienced severe cognitive impairment and no behaviors. A Nurse's note dated 05/16/13 at 3:00 p.m. indicated, "Res [resident] awakes aggressive [sic] behavior toward staff, hitting, spitting grabbing equipment. One on one attempt et unsuccessful. Res states what [Resident #26] wants et [and] nurse attempts need et becomes more agitated. Res continues aggressive behavior. Nurse notifies MD [physician] on call new order received...Res. daughter called able to visit et behaviors calmed with success..." The nursing notes lacked any further documentation until			

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	05/22/13 at 8:00 a.m., which indicated Resident #26 was "...very confused...". A Physician's Telephone Order dated 05/16/13 at 4:30 p.m., indicated a new order was received for, "Risperdal [an anti-psychotic medication] 2 mg by mouth three times daily..." The May 2013 MAR (Medication Administration Record) indicated Risperdal 2 mg began to be administered on May 18.2013. A Physician's Telephone Order dated 05/28/13 indicated the Risperdal was revised to 2 mg by mouth daily. The Nurse's notes lacked any documentation from 05/22/13 at 8:00 a.m. through 05/28/13 at 1:20 p.m. r/t monitoring the Risperdal or the behaviors. A Nurse's noted dated 05/29/13 at 8:00 a.m. indicated Resident #26 was "...pleasant and cooperative with staff. will continue to monitor." A Nurse's note dated 05/30/13 at 3:00 p.m. indicated, "Res having noted behavior while in shower assistance per nurse given to complete shower.			

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	Res struck staff, yelling out, cursing ..." The Nurse's notes lacked any further documentation until 06/05/13 at 8:00 a.m. which indicated, "...Resident very confused..." A Physician's Telephone Order dated 06/08/13 at 12:15 p.m. indicated the Risperdal was increased to 2 mg by mouth twice daily. The Target Behavior Summary with Details Report from 05/16/13 through 06/08/13 were reviewed and indicated, Resident #26 experienced one episode of becoming aggressive, hitting and yelling staff on 05/24/13. The report lacked any documentation related to episodes of behaviors to indicated a dose increase was needed. During an interview on 06/28/13 at 10:40 a.m., the SSD indicated there was no formal monitoring plan of specific identified behaviors for Resident #45 or Resident #26. 4. Resident #15 was observed on 6/24/13 at 9:45 a.m., to be lying in bed. Resident #15 was observed, at that time, to be experiencing no signs or symptoms of anxiety or psychosis.			

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	Resident #15 was observed on 6/25/13 at 10:00 a.m,. to be up in a wheelchair in the hall. Resident #15 was observed, at that time, to be experiencing no signs or symptoms of anxiety or psychosis. The clinical record of Resident #15 was reviewed on 6/26/13 at 10:48 a.m. Resident #15 had diagnoses including, but not limited to, Parkinson's disease, mood disorder, depression, and dementia, Resident #15 had a physician's order, dated 6/24/13, for Risperdal 0.5 mg(milligram) at HS (hour of sleep), for a diagnosis of "flight of ideas." A quarterly Minimum Data Set (MDS), dated 5/2/13. indicated the resident did not have any behaviors. A significant change MDS, dated 3/12/13, indicated the resident had delusions. The resident's care plan for psychotropic drug use, dated 6/26/13, included, but was not limited to, the following: Risperdal (risperidone) as ordered Diagnosis: psychosis Behavioral symptoms drug is used to treat: agitation, restlessness			

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	Interventions included, but were not limited to, the following: Monitor side effects Monitor for drug related cognitive/behavioral impairment Monitor for drug-related discomfort Non-drug interventions LCSW (licensed clinical social worker) visits PRN (as needed) The resident's care plan for psychosocial well-being or safety risk, dated 6/19/13, included bur were no limited to, the following: Hallucinations: sees children or other people/animals in room Delusions: believes she is in prison, believes there are children in room, and want to go to school Interventions included, but were not limited to, the following: Rule out delirium Approach when hallucinating, delusional or expressing potentially harmful suspicions: approach calmly, talk quietly, redirect with talking about her writing, offer snack/drink, talk about or show movie due to past dream experience Resident-specific familiar objects, signs, pictures, items, distraction strategies: reassure Psychotropic medications			

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	LCSW PRN A nursing Progress Note, dated 3/23/13 at 3:00 a.m., indicated Resident #15 was alert with confusion. A nursing Progress Note on 5/8/13 at 8:00 a.m., indicated Resident #15 was confused to facts. A nursing Progress Note, dated 6/7/13 at 9:00 p.m., indicated Resident #15 reverts to past at times and thinks she is directing plays. . An interview with the SSD (Social Services Director) on 6/27/13 at 2:49 p.m., indicated the resident is monitored by nursing for interventions regarding confusion, behaviors, and after residents are placed on psychotropic medications. An interview with the ADoN (Assistant Director of Nursing) on 6/27/13 at 1:56 p.m., indicated if a resident receives any new orders, has a fall, or other significant changes or behavior changes, the resident is listed on the resident critical charting form and the nurses are to document in the nurse's notes regarding the issue. During an interview with the SSD on			

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	7/2/13 at 8:15 a.m., there was not a monitoring tool for psychotropic medications. During an interview with the SSD on 7/2/13 at 11:35 a.m., the SSD indicated Resident #15 had not been visited by the LCSW (Licensed Clinical Social Worker) since March, 2013. 3.1-48(a)(4) 3.1-48(b)(1)			

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview, and record review, the facility failed to store foods under sanitary conditions, in that foods were not sealed or dated after being opened. This had the potential to affect 64 of 64 residents who resided at the facility. Findings include: During the initial tour of the kitchen on 6/24/13 at 9:00 a.m., a package of buns, on a bread pallet in the kitchen, were observed opened with no date present. An opened bag of rice and two (2) bulk-sized bags of powdered milk were observed, in the dry storage area, opened with no date. During an interview with the Dietary Manager (DM) on 6/24/13 at 8:40 a.m., she indicated all opened products are to be sealed after opening and dated. A document, titled "Food Storage Charts," dated 4/2013 and obtained	F000371	It is the policy of Mt Vernon Nursing and Rehab Center to store, prepare, distribute and serve food under sanitary conditions. This alleged deficit practice has the potential to affect all residents. No residents were identified to have any ill effects. Dining Manager re-educated all dining services staff on the storing of foods under sanitary conditions and dating the foods after opening. The DM further re-educated the staff on the food storage charts indicating the consistent practice of proper storage. Large containers have been purchased to enhance the proper storage of bulk food.The DM will monitor daily the proper storage of the food, ensuring it is airtight and dated. The RD will monitor with sanitation rounds 1 x weekly for 4 weeks and 1x monthly thereafter; the Administrator will complete sanitation rounds 2x's weekly for 2 months and weekly thereafter. The audits will be forwarded to the QA committee monthly for 6 months with further recommendations as indicated.	08/01/2013

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	from the DM on 7/1/13 at 2:00 p.m., indicated opened rolls expired after two (2) weeks, rice would expire after tow (2) years and was to be kept dry in an air tight container after opened, and powdered milk would expire three (3) months after opened. 3.1-21(i)(3)			

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and	F000441	It is the policy of Mt Vernon Nursing and Rehab Center to	08/01/2013

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	record review, the facility failed to ensure hand hygiene was completed between residents during the medication pass, for 1 of 3 nurses observed passing medications, in that the nurse did not sanitize her hands between residents and touched residents and mopped her brow. (LPN #2) Finding includes: LPN #2 was observed on 6/25/13 at 4:09 p.m. to administer medications to Resident #96. She gave the resident the medication, touched the resident's phone and wheelchair and then took a tissue and wiped her brow. She then prepared medications for Resident #35. She did not use hand sanitizer or wash her hands between the two residents. LPN #2 administered medications to Resident #35, then returned to the medication cart and wiped her brow with a tissue. She then prepared and administered medications to Resident #57. The LPN was interviewed at that time. She indicated she had alcohol gel in her pocket and took it out of her pocket.		ensure an Infection Control Program designed to provide a safe sanitary and confortable environment and to help prevent the development and transmission of disease and infection.Nurses were all inserviced 7/12/2013 on the hand washing policy and procedure after each direct resident contact. Random hand hygiene audits of nursing staff will be conpleted by Nursing Administration 7/7 days x 2 weeks; then weekly x 4 weeks; and then monthly x 2. Recommendations will be forwarded to the QA committee for 6 months for further monitoring as indicated.	

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	The policy and procedure for Hand Hygiene - Alcohol Based Hand Rub, dated January 2004 and revised November 2011 was provided by the Director of Nursing on 6/28/13 at 12:30 p.m. The policy and procedure included, but was not limited to, the following: Examples of when an alcohol based hand rub may be used: -if hands are not visibly soiled -before having direct contact with residents -after contact with a resident intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident) -After contact with body fluids or excretions... -after contact with inanimate objects in the immediate vicinity of the resident 3.1-18(l)			

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F000465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the environment was sanitary and comfortable for 6 of 6 resident rooms observed during stage I, in that bathroom floors were soiled/stained, resident equipment was soiled and the kitchen floor and equipment were soiled during the environmental tour. (Room 118, Room 119, Room 150, Room 153, Room 156, and Room 161) Findings include: 1. Room 118 was observed on 6/24/13 at 10:47 a.m. The base of the toilet was soiled with loose dirt. The corners and edges of the bathroom floor were soiled. 2. Room 119 was observed on 6/25/13 at 2:00 p.m. There was an odor of feces in the room. The bathroom floor was soiled with dirt and debris and there was an odor in the bathroom. 3. Room 150 was observed on 6/24/13 at 11:26 a.m. The bathroom	F000465	It is the policy of Mt Vernon Nursing and Rehab Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.The identified floors for 6 out of 56 resident bathrooms were re-stripped and re-waxed to assure that there was no soil in the corners and at the edges. The caulk around one commode was re-applied to assure there was no stain/soil. The mechanical lifts were cleaned and will be repainted with new non-skid strips applied. Maintenance and Housekeeping will assess weekly with their departmental rounds.The housekeeping staff were re-educated to dust the large commercial washers daily with the stiff brush provided. One residential washing machine was scheduled to be replaced prior to survey date and was replaced on 7/1/2013.The DM has been replacing the carafe's as scheduled. The staff were re-educated on proper floor mopping techniques and removing all crumbs prior to storing the toaster. Dietary staff meet daily 5/7 days to monitor cleanliness and the delegation of the responsibility.The	08/01/2013

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	floor was soiled in the corners and edges. 4. Room 153 was observed on 6/25/13 at 2:30 p.m. The bathroom floor was soiled with loose dirt. 5. Room 156 was observed on 6/25/13 at 9:00 a.m. The bathroom floor was soiled and stained in the corners and edges. The caulking around the toilet was soiled/stained. The toilet seat had dried liquid on it. 6. Room 161 was observed on 6/25/13 at 2:33 p.m. The bathroom floor was soiled in the corners and edges. 7. During the tour of the general environment on 6/26/13 at 10:10 a.m., the scales in the men's shower room were observed to be soiled and a washcloth was observed to be wrapped around the shower nozzle in the women's bathroom on the lower level. The mechanical lifts were soiled on both units. 8. During the tour of the laundry room on 6/26/13 at 10:30 a.m., the floor was observed to have water running across it, the washing machines were soiled, and a fan with lint on it was		Administrator will monitor the environment through daily/weekly rounds with the DON, the DM, the Maint Dir. and the Hskp Dir. Further departmental audits are completed weekly, monthly and quarterly by the Regional Team. Project requests are submitted to renovate areas as indicated by the aforementioned audits. The Administrator will forward the audits monthly to the QA committee x 6 months with request for follow up recommendations as indicated.	

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	observed to be sitting on the folding table and blowing. During an interview with LA #1 on 6/26/13 at 10:30 a.m., she indicated the water had been across the floor throughout the week. She indicated she did not know when it first appeared as she had been on vacation last week and had returned this week and it was there. 10. During a tour of the kitchen on 6/28/13 at 11:30 a.m., the floors were soiled and sticky, a toaster had been stored under a prep table with crumbs on the top of it, and the coffee carafes were stained. During an interview with the DM (dietary manager) on 6/27/13 at 11:30 a.m., indicated she had been soaking the carafes frequently and was ordering new items to replace them. During an interview with the Administrator (Adm) on 7/1/13 at 4:00 p.m., she indicated the dietary staff is responsible for sweeping the kitchen floor. She indicated the housekeeping department is responsible for the in-depth cleaning of the kitchen floor as well as the facility cleaning.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON NURSING AND REHABILITATION CENTER	1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(f)			