

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155690	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/29/2014
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NAME OF PROVIDER OR SUPPLIER  MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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F000000	<p>This visit was for the Investigation of Complaints IN00152143 and IN00153446.</p> <p>Complaint IN00152143 Substantiated. Federal/State deficiencies related to the allegation are cited at F309, F314, and F441.</p> <p>Complaint IN00153446 Substantiated. Federal/State deficiencies related to the allegation are cited at F309, F441, and F469.</p> <p>Survey dates: July 28, and 29, 2014</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census payor type: Medicare: 0 Medicaid: 41 Other: 6 Total: 47</p>	F000000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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F000309 SS=D	<p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure wound treatments were completed as ordered by the physician in order to promote wound healing and/or prevent contamination of the wound for 2 of 4 residents reviewed for wound care in a sample of 5. (Resident #E and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #E was reviewed on 7/28/14 at 3:35 p.m. Diagnoses for the resident included, but</p>	F000309	<p>F-309</p> <p>1. Resident E's treatment was completed as ordered and the treatment record was updated to clearly reflect the start date of the treatment (i.e., line to start date). Resident E's physician was notified. Order to monitor dressings every shift to confirm they are changed as per order and to assure that they are intact was added to the treatment record.</p> <p>Resident C no longer resides at the facility.</p> <p>2. All Residents treatment records were reviewed to ensure clarity in start/stop times as</p>	08/18/2014

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	<p>were not limited to, left below the knee amputation, morbid obesity, diabetes mellitus type 2, peripheral vascular disease, and depression.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/11/14, indicated the resident had no cognitive impairment and required extensive assistance from the staff for dressing and bathing.</p> <p>A health care plan problem, dated 7/24/14, indicated the resident had a diabetic ulcer to the right plantar region of the right foot. Approaches for this problem included, but were not limited to, "Treatment per order".</p> <p>A "Podiatry Exam" note, dated 7/24/14, indicated the resident had been seen by the podiatrist on that date. The note indicated toenail care was provided and "macerated skin noted around healing plantar ulcers which measure 2.5 by 1.0 cm [centimeters] and 0.5 by 0.5 cm with granular tissue" was noted on the bottom of the resident's right foot. The note indicated a treatment was completed by the podiatrist and a treatment order was written for the wound for the staff to continue.</p> <p>The treatment order, dated 7/24/14, indicated "Please apply betadine/gauze</p>		<p>applicable. Any areas of concerns with treatments were addressed immediately. All residents with dressings were observed to assure dressings were intact and the treatments are completed as ordered. No issues noted. Orders received to monitor dressings every shift added to treatment records of all residents with dressings.</p> <p>3. The Skin Management Program was reviewed with no changes. Nursing staff were re-educated regarding treatment orders and the importance of clarity in transcription of orders, completing treatments as ordered as well as monitoring the dressings to assure that they remain intact. C.N.A.'s re-educated to report to nurses any new areas noted during care, and to notify nurse if dressings are not intact (i.e., removed by resident or fallen off) to known wounds. The DON and or designee will monitor treatment records of all residents with current dressings, as well as any resident with new orders for dressings, 5x /week x 4 weeks, then weekly x 4 weeks then monthly thereafter, to assure compliance with dressing changes as per order as well as proper documentation of dressing changes.</p> <p>4. The DON and or designee will report the findings of these audits and any corrective action taken to the QA committee monthly x</p>				

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	<p>dressing to plantar right foot macerated skin daily times 10 days."</p> <p>During an observation of a dressing change performed by LPN #2 on 7/28/14 at 2:15 p.m., the following was noted:</p> <p>LPN #2 obtained the proper supplies and entered the resident's room. She informed the resident of the procedure and removed the resident's protective boot from the right lower leg.</p> <p>The resident's sock was then removed exposing the dressing on the resident's right foot. The dressing was dated 7/24/14. LPN #2 removed the dressing and prepared to complete the treatment. When she attempted to apply the betadine to the dressing, she had to open the bottle and remove the protective tab on the new bottle in order to apply the betadine to the dressing.</p> <p>During the wound observation, two open areas were noted on the bottom of the right foot surrounded by pinkish skin. One area was noted to be larger than the other. LPN #2 did not measure the wounds at this time. She completed the dressing procedure and dated the dressing 7/28/14.</p> <p>During the dressing change, Resident #E</p>		<p>3months, then quarterly thereafter ongoing. Revisions will be made to the plan(i.e., frequency of monitoring increased if non-compliance observed ordecreased if increased compliance observed), if warranted.</p> <p>5.8-18-14</p>	

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	<p>indicated the dressing being removed was the same dressing put on by the Podiatrist when he was here "last week". He indicated the dressing had not been changed since the Podiatrist had been at the facility.</p> <p>LPN #2 was interviewed on 7/28/14 at 2:25 p.m. She indicated the betadine bottle had not been opened until today and the date on the dressing indicated the treatment had not been completed daily as ordered by the Podiatrist.</p> <p>The July 2014 treatment sheets for Resident #E included the new order received from the Podiatrist on 7/24/14. The order had been transcribed on the treatment sheet, but no line had been drawn over to the initial start date in order to make it clear as to when the treatment was to be done. The treatment sheet lacked any documentation of the daily treatment having been done since it was ordered on 7/24/14.</p> <p>The DoN was interviewed on 7/28/14 at 2:30 p.m. Additional information was requested related to the treatment having not been completed as ordered. A request was made for the wound to be measured during the treatment to be completed on 7/29/14.</p>			

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	<p>Review of wound measurement, provided by the DoN on 7/29/14 at 9:30 a.m., were as follows:</p> <p>The larger area on the bottom of the right foot measured 2.0 cm by 1.8 cm with a depth less than 0.1 cm. The smaller area on the bottom of the right foot measured 0.9 cm by 0.8 cm and measured less than 0.1 cm.</p> <p>2. The clinical record for Resident #C was reviewed on 7/28/14 at 3:55 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, end stage renal disease, bi-polar disorder, charcot ankle disease, and cellulitis of the right lower extremity.</p> <p>A Nurse Practitioner note, dated 7/7/14 indicated the resident had cellulitis of the right lower extremity and antibiotic therapy was ordered for ten days. The note also indicated the resident had a right foot ulcer.</p> <p>A health care plan problem, dated 5/20/14, indicated the resident had a vascular ulcer on the right outer ankle. Two of the approaches for this problem were for the staff to complete "Treatment as ordered and Monitor for signs/symptoms of infection (e.g., redness, warmth, drainage, odor,</p>			

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	<p>increased temperature) and notify physician if observed."</p> <p>The July 2014 Medication Administration Record (MAR) indicated the current treatment for the right ankle wound was as follows:</p> <p>"Cleanse right out ankle with soap and water, apply skin prep to peri wound, apply Maxorb rope to wound bed moistened, cover with foam, secure with border gauze, change every 5 days and as needed." The original date of this order was listed as 5/16/14 and it had also been reordered on 6/26/14.</p> <p>The July 2014 MAR documented the wound care treatment having been completed on 7/8/14 and was due to be completed again in 5 days on 7/13/14. The MAR indicated the wound measured 1.5 cm by 2 cm on 7/8/14</p> <p>The clinical record indicated the resident was transferred from the dialysis provider location to the hospital and admitted there for treatment on 7/12/14.</p> <p>Dialysis RN #1 (employed by the dialysis provider) was interviewed on 7/29/14 at 2:25 p.m. She indicated she had provided care to Resident #C at the dialysis center on 7/12/14. She indicated</p>			

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	<p>while checking pulse of the lower extremities during the dialysis treatment, she noted the resident had a sock on her right foot that was wet with greenish drainage. When she attempted to remove the sock to see the location of the drainage, some areas of the drainage were dried and the sock was stuck to the wound in some areas. Dialysis RN indicated there was no dressing on the wound, just the sock. She indicated the dialysis staff felt the resident might be septic due to the condition of the wound and the green drainage. She was sent from the dialysis unit to the hospital for evaluation following the dialysis treatment and admitted for treatment.</p> <p>A nursing note, dated 7/12/14 at 6 p.m. indicated the facility had been notified that the resident had been admitted to the hospital for "sepsis of right foot."</p> <p>The clinical record for Resident #C, dated from 7/8/14 thru 7/12/14, lacked any information related to monitoring of the status of the right ankle dressing and/or any drainage having been noted from the wound.</p> <p>The Administrator and DoN were interviewed on 7/29/14 at 4:25 p.m. Additional information was requested related to the lack of a dressing having</p>			

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	<p>been on the wound when she was sent to the dialysis center and the drainage from the wound.</p> <p>The DoN indicated the resident had a long history of problems with this chronic ulcer and doppler studies had been done and amputation had even been considered. The facility failed to provide any additional information as of exit on 7/29/14.</p> <p>3. Review of the current facility policy, revised 3/2010, titled "Skin Management Program", provided by the RN Consultant on 7/29/14 at 2:15 p.m., included, but was not limited to, the following:</p> <p>"Purpose: It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers and other skin alterations unless the individual's condition demonstrates that the development is clinically unavoidable.</p> <p>Procedure:</p> <p>Assessment-</p> <p>...2. Residents who receive assistance with bathing and/or peri-care will be observed daily by nursing staff and any</p>			

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F000314 SS=D	<p>note of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations will be reported to the licensed nurse for further assessment.</p> <p>...5. Interventions will be implemented according to the individual residents risk factors that will best reduce the risk of development of pressure ulcers and/or promote the most effective healing of existing areas.</p> <p>...9.... Daily documentation will be completed on all open areas related to pressure, venous, arterial and diabetic wounds using the form "Pressure, Venous, Arterial &amp; Diabetic Ulcer Daily Monitoring...."</p> <p>This federal tag relates to Complaint IN00152143 and IN00153446.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent</p>						

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	<p>infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure pressure ulcer treatments were provided in a manner to promote healing of the wound for 1 of 1 resident reviewed for pressure ulcer treatment in a sample of 5. (Resident #F)</p> <p>Findings include:</p> <p>The clinical record for Resident #F was reviewed on 7/28/14 at 2:40 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, diabetes mellitus, and hypertension.</p> <p>A significant change MDS, dated 5/21/14, indicated the resident was cognitively impaired and required extensive assistance from the staff for toileting and bathing.</p> <p>A physician's order, dated 7/24/14, indicated a treatment had been ordered for a pressure area on the residents coccyx. The treatment indicated the staff were to "Cleanse coccyx with soap and water, apply skin prep to peri wound, then apply optifoam and border gauze every five days and prn [as needed] for soilage times two weeks."</p>	F000314	<p>F-314</p> <p>1. Resident F's treatment was completed immediately.</p> <p>2. All Residents treatment records were reviewed to ensure clarity in start/stop times as applicable. Any areas of concerns with treatments were addressed immediately. All residents with dressings were observed to assure dressings were intact and the treatments are completed as ordered. No issues noted. Orders received to monitor dressings every shift added to treatment records of all residents with dressings.</p> <p>3. The Skin Management Program was reviewed with no changes. Nursing staff were re-educated regarding treatment orders and the importance of clarity in transcription of orders, completing treatments as ordered as well as monitoring the dressings to assure that they remain intact. C.N.A.'s re-educated to report to nurses any new areas noted during care, and to notify nurse if dressings are not intact (i.e., removed by resident or fallen off) to known wounds. The DON and or designee will monitor treatment records of all residents with current dressings, as well as any resident with new orders for dressings, 5x /week x 4 weeks, then weekly x 4 weeks then monthly thereafter, to assure</p>	08/18/2014			

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	<p>The MAR indicated the treatment was completed as ordered on 7/24/14 and was due to be done again on 7/29/14. The "Initial Pressure Ulcer Assessment" form, dated 7/24/14, indicated the wound measured 0.2 by 0.2 with a depth less than 0.1 cm.</p> <p>LPN #2 was interviewed on 7/28/14 at 1:35 p.m. A request was made to check the status of the dressing on Resident #F's wound.</p> <p>During an observation with LPN #2 on 7/28/14 at 1:40 p.m., Resident #F was resting in bed on her back. LPN #2 assisted the resident to turn and opened the resident's brief to check the status/date of the dressing. There was no dressing in place on the resident's coccyx. The resident's coccyx area was dark pink in color with a very small denuded area consistent with the size noted previously near the coccyx.</p> <p>LPN #2 was interviewed on 7/28/14 at 1:45 p.m. She indicated she was unaware that there was no dressing in place on the resident's wound. She indicated the CNA assigned to the resident had not told her of the absence of a dressing on the wound and she did not know how long it had been without a dressing.</p>		<p>compliance with dressing changes as per order aswell as proper documentation of dressingchanges.</p> <p>4.The DON and or designee will report the findings of these audits and any corrective action taken to the QA committee monthly x 3months, then quarterly thereafter ongoing. Revisions will be made to the plan(i.e., frequency of monitoring increased if non-compliance observed or decreased if increased compliance observed), if warranted.</p> <p>8-18-14</p>				

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	<p>Review of the current facility policy, revised 3/2010, titled "Skin Management Program", provided by the RN Consultant on 7/29/14 at 2:15 p.m., included, but was not limited to, the following:</p> <p>"Purpose: It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers and other skin alterations unless the individual's condition demonstrates that the development is clinically unavoidable.</p> <p>Procedure:</p> <p>Assessment-</p> <p>...2. Residents who receive assistance with bathing and/or peri-care will be observed daily by nursing staff and any note of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations will be reported to the licensed nurse for further assessment.</p> <p>...5. Interventions will be implemented according to the individual residents risk factors that will best reduce the risk of development of pressure ulcers and/or promote the most effective healing of existing areas.</p>			

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F000441 SS=D	<p>...9... Daily documentation will be completed on all open areas related to pressure, venous, arterial and diabetic wounds using the form "Pressure, Venous, Arterial &amp; Diabetic Ulcer Daily Monitoring...."</p> <p>This federal tag relates to Complaint IN00152143.</p> <p>3.1-40(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <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</p>			

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NAME OF PROVIDER OR SUPPLIER  MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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	<p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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 ensure handwashing and infection control prevention practices were followed during 1 of 1 dressing change observed for handwashing and infection control in a sample of 5. (Resident #E)</p> <p>Findings include:</p> <p>The clinical record for Resident #E was reviewed on 7/28/14 at 3:35 p.m. Diagnoses for the resident included, but were not limited to, left below the knee amputation, morbid obesity, diabetes mellitus type 2, peripheral vascular disease, and depression.</p> <p>A health care plan problem, dated 7/24/14, indicated the resident had a diabetic ulcer to the right plantar region of the right foot. Approaches for this problem included, but were not limited</p>	F000441	<p>F-441</p> <p>1. Resident E was assessed for signs and symptoms of infection with none noted. LPN # 2 was immediately re-educated on proper infection control technique during dressing change, including hand washing and placement of supplies for dressing changes.</p> <p>2. As all residents requiring dressing change could be affected, Nursing staff re-educated on proper infection control technique during dressing change procedures including hand washing and placement of supplies for dressing changes with return demonstration.</p> <p>3. Nursing staff re-educated on proper infection control technique during dressing change procedures including hand washing and placement of supplies for dressing changes with return demonstration. The DON and/or designee will monitor dressing changes 3 x / week x 4 weeks, weekly x 4 weeks then</p>	08/18/2014

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	<p>to, "Treatment per order".</p> <p>The treatment order, dated 7/24/14, indicated "Please apply betadine/gauze dressing to plantar right foot macerated skin daily times 10 days."</p> <p>During an observation of a dressing change performed by LPN #2 on 7/28/14 at 2:15 p.m., the following was noted:</p> <p>LPN #2 obtained the proper supplies and entered the resident's room. The resident was up in his wheelchair with his right leg extended out in front of him. LPN #2 informed the resident of the procedure and removed the resident's protective boot from the right lower leg. Without washing her hands, LPN #2 donned gloves and placed the bottle of Betadine solution which was inside of a plastic zip lock bag on the bare floor. She placed the unopened 4 by 4 dressing on the floor and placed the tape on top of the dressing. She squatted down in front of the resident and then removed the resident's sock exposing the dressing on the resident's right foot. No protective clean surface was placed under the resident's foot. LPN #2 removed and disposed of the dressing and obtained clean gloves without washing her hands.</p> <p>LPN #2 removed the bottle of Betadine</p>		<p>monthly thereafter atvaried times on varied shifts, to assure proper infection control techniqueduring dressing changes. Should concerns be identified, immediate correctiveaction shall be taken.</p> <p>4. The DON and/or designee will report the findings of the aforementioned observations and any corrective actions taken to the QAcommittee monthly x 3 months and quarterly thereafter. Revisions will be madeto the plan (i.e., frequency of monitoring increased if non-compliance observedor decreased if increased compliance observed), if warranted.</p> <p>8-18-14</p>	

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	<p>from the plastic bag. She picked the package of 4 by 4 dressing up from the floor and opened it. Betadine was applied to the dressing and the wound care was completed, taped, and the dressing was dated. LPN #2 donned new gloves.</p> <p>She picked up the plastic bag containing the bottle of betadine and placed it on an over the bed table in the room and then put the resident's boot back on his right foot. She washed her hands at this time. This was the only handwashing observed during the dressing change observation.</p> <p>She picked up the plastic bag containing the Betadine and left the room. She indicated she was taking the bottle of Betadine back to the treatment cart. A request was made for her to put the bottle of Betadine into a new clean baggie and she indicated she would.</p> <p>The Don and RN Consultant were interviewed on 7/29/14 at 1:55 p.m. They indicated wound care items should never be placed on the floor.</p> <p>Review of the current facility procedure, dated 9/05, titled "Clean Dressing Change Procedure", provided by the RN Consultant on 7/29/14 at 2:15 p.m., included, but was not limited to, the</p>			

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F000469 SS=D	<p>following:</p> <p>"Purpose: To protect open wounds from contamination, to absorb drainage, and to promote healing.</p> <p>...Procedure:</p> <p>...3. Wash hands thoroughly.</p> <p>4. Place treatment chux or papertoweling on overbed table and treatment chux or protective liner under resident's wound area...."</p> <p>This federal tag relates to Complaint IN00152143 and IN00153446.</p> <p>3.1-19(l)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, record review, and interview, the facility failed to ensure an effective pest control program was in place to prevent mice from soiling resident areas in 1 of 7 rooms observed for the presence of pest droppings and soilage. This had the potential to affect 30 of 30 residents residing in the front</p>	F000469	F-469 1.No residents were affected. The hole noted to bein the wall in room 408 was immediately repaired, and the room was deep cleaned. Indiana Pestcontrol was notified and the outside of the building was treated, and thebuilding was checked for any other issues and potential entry	08/18/2014			

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	<p>half of the building. (Room 408)</p> <p>Findings include:</p> <p>The Administrator was interviewed on 7/29/14 at 2:45 p.m. He indicated the facility had pest control treatment services in the building as part of their routine program on 5/15, 6/18, and 7/17/14. He indicated the treatments given included treating for mice.</p> <p>During a tour with the Administrator, conducted on 7/29/14 from 3:45 p.m. thru 4 p.m., 7 rooms were checked for the presence of pest droppings (feces) and soilage. The following was observed:</p> <p>Room 408:</p> <p>No residents resided in this room at the current time. Multiple bags of clothing items were on the floor of the room which had been removed from the residents drawers and/or closets.</p> <p>The Administrator indicated he thought these items were from a discharged resident and had not been picked up yet.</p> <p>The room contained two closet areas that had built in shelves and drawers as well as the clothing racks.</p>		<p>sites.</p> <p>2.All residents have the potential to be affected.Indiana Pest Control was notified, the outside of the building was treated, andthe building was checked for any other issues and potential entry sites. Allrooms deep cleaned and are on deep clean schedule. Staff re-educated to monitorrooms, and report any findings immediately.</p> <p>3.The administrator and/or designee will check allrooms (whether occupied or unoccupied) 5 x/ week x 4 weeks, 3 x/ week x 4weeks, then weekly thereafter to assure any pest control issues are immediatelyaddressed. Should concerns be observed, immediate corrective action shall betaken.</p> <p>4.The Administrator and/or designee will reportthe findings of the aforementioned observations and any corrective actionstaken to the QA committee monthly x 3 months then quarterly thereafter.Revisions will be made to the plan (i.e., frequency of monitoring increased ifnon-compliance observed or decreased if increased compliance observed), ifwarranted.</p> <p>5.8-18-14</p>				

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	<p>In the right closet area, there was a large amount of small black formed debris which appeared to be mouse feces present on the floor. The closet shelves and closet drawers also had a large amount of the black debris. Other small paper debris was also noted in the areas.</p> <p>In the left closet area a large amount of small black formed debris which appeared to be mouse feces was present on the floor. The closet shelves and closet drawers also had a large amount of the black debris. Other small paper debris was also noted in the areas. This closet also had a hole in the wall on the back left lower corner of the closet. Lots of debris and what appeared to be mouse fecal matter was noted around the area.</p> <p>The bedside stand located next to closet contained three drawers. The black debris which appeared to be mouse feces was present in each drawer.</p> <p>The Administrator was interviewed during this observation on 7/29/14 at 4 p.m. He indicated the hole appeared to be a "mouse hole" and the black debris appeared to be "mouse droppings (feces)." When queried if he had been made aware of the mouse hole and mouse droppings so that mice could no longer get into the room and/or unit, he</p>			

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	<p>indicated "no." He was unaware of the problem until this tour. He indicated the hole would be repaired and the areas quickly cleaned.</p> <p>Review of the discharge list, provided by the DoN on 7/28/14 at 1 p.m., indicated the resident who had resided in room 408 had been officially discharged on 7/19/14.</p> <p>During an observation with the DoN on 7/29/14 at 4 p.m., she observed the condition of the room as noted above. When queried if she was aware of the mouse hole in the closet and the mouse droppings, she indicated "No".</p> <p>The Housekeeping Director was interviewed on 7/29/14 at 4:10 p.m. She indicated she was unaware of the mouse hole and the mouse droppings in room 408.</p> <p>This federal tag relates to Complaint IN00153446.</p> <p>3.1-19(f)(4)</p>			