STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1630 S COUNTY FARM RD WARSAW, IN46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 31, November 1, 2, 3, 2011 Facility number: 000017 Provider number: 155049 AIM number: 100273830 Survey team: Tim Long, RN, TC Diane Nilson, RN (10/31/11, 11/1/11) Julie Wagoner, RN Christine Fodrea, RN Census bed type: SNF: 17 SNF/NF: 84 Total: 101 Census Payor type: Medicare: 18 Medicaid: 66 Other: 17 Total: 101 Sample: 21 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

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 11/10/11 by Suzanne Williams, RN			
F0250 SS=D	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 observations, record review, and interview, the facility failed to ensure the facility provided social service interventions to assist a new resident with behavioral needs in adjusting to his new environment. This affected 1 of 8 residents reviewed for behaviors in a sample of 21. (Resident #31) Findings include: During the initial tour of the facility, conducted on 10/31/11 between 10:30 A.M. - 11:30 A.M., the Assistant Director of Nursing indicated Resident #31 was nonverbal or had very slurred speech, had experienced a stroke in the past, and required extensive staff assistance for activities of daily living. Resident #31 was observed on 11/01/11 at 1:00 P.M., propelling himself slowly in a wheelchair around the facility. The resident was noted to nod his head when asked questions by staff passing him in the hallway.	F0250	Resident 31 did not suffer any negative consequences related to facility adjustment. All Social Services interventions have been reviewed & updated. Resident & responsible partry have not voiced or presented any concerns related to his deficiency. All newly admitted residents have the potential to be affected by this finding. To ensure compliance in the future, the pre-admission assessment is now structured so that when psychoactive medications and/or behavior issues are noted prior to admission, the Social Services department will be notified in order to have an appropriate plan of care including interventions for behaviors upon admission. Monitoring of this system will be completed at least twice monthly during the next 90 days, then monthly per facility Quality Assurance Program using the Behavior & Antipsychotic Medication Review tool (Attachment A). Monitoring will be completed by the Social Service staff or designee.	12/03/2011

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	The clinical record for Resident #31 was reviewed on 11/02/11 at 10:30 A.M. Resident #31 was admitted to the facility from another long term care facility on 03/22/11, with diagnoses including, but not limited to, behavioral disturbance, cognitive impairment, and late effect CVA (cerebral vascular accident). The resident's admitting physician's order, included the medications, Risperdone (an antipsychotic) 0.5 mg twice a day, Diavaproex sodium (an anticonvulsant used as a mood stabilizer) 500 mg twice a day, Risperdal consta (an antipsychotic) 25 mg IM (intramuscularly) once every 14 days, zyprexa zydis (an antipsychotic) 5 mg once a day, Cymbalta (an antidepressant) 60 mg once a day, and oxycontin (a pain medication) 20 mg twice a day. Review of the resident's Minimum Data Set (MDS) from 8/9/11 for a significant change, indicated the resident had moderately impaired cognition and had behaviors of being physically and verbally abusive. The resident also exhibited symptoms of depression. Review of nursing progress notes, dated 04/04/11 indicated the resident had gotten very agitated with staff during care and had cursed and swung at staff. The note			

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	also indicated the resident had refused a medication three days in a row and would get very angry when approached with the medication. Nursing note on 04/07/11 indicated the resident was refusing incontinence care. On 04/08/11 Resident #31 became agitated with another resident and yelled and shook his finger at the resident. He was also refusing assistance with dressing, despite staff attempts at reapproaching him later. On 04/14/11 social service staff spoke with the resident's spouse about the need to see a psychiatrist to manage the resident's psychiatric medications. She requested a specific, local psychiatrist who had previously seen the resident. On 04/15/11 the resident swore loudly in the dining room, but was unable to verbalize what had upset him. On 04/16/11 the resident had refused to get up and had refused care. A nursing progress note, dated 04/18/11 indicated the resident's wife had indicated the resident could be left in bed for breakfast because this had been his routine prior to admission to this facility.			

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	On 04/21/11 the resident refused all of his medications and different nursing staff were unable to convince the resident to take his medication. The resident's wife came in later in the day and did convince him to take his medications. On 04/22/11 the resident refused his morning medications and pointed his finger at staff. On 04/26/11 the resident's spouse was informed of the psychiatric appointment scheduled for 05/04/11 with the psychiatrist she had requested. On 05/24/11 the resident's spouse was informed of the next psychiatric appointment scheduled for 06/01/11 and she indicated she could not accompany the resident to the appointment. On 05/31/11 the social service staff spoke to the resident's spouse about changing the resident's psychiatrist to the facility's psychiatrist due to the spouse's inability to accompany her husband to appointments at the outside psychiatrists' office. The 06/01/11 appointment was canceled. On 06/09/11 the wife's spouse was asked to complete paperwork for the facility's psychiatrist.			

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	On 06/12/11 and 06/14/11 the resident refused treatments and/or medications. On 06/18/11 the resident had refused medications and started yelling and grabbed staff's arm during treatment of his wounds. The resident also refused to get up for lunch. On 06/20/11 the resident refused his medications and had also yelled at staff during wound treatments. On 06/22/11 the resident swore at staff and refused to allow staff to treat his wounds. On 06/23/11 the resident refused mediations. The resident also had refused to allow the wound center to treat his wounds and refused to allow facility staff to treat his wounds. On 06/24/11 the resident became combative and yelled when staff tried to provide incontinence care and get the resident up for the evening meal. On 06/25/11 the resident refused his morning medications and treatments. On 06/26/11 and 06/27/11 the resident refused his morning medications.			

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	On 06/30/11 the resident struck a CNA providing care for him. Review of the April behavior monitoring records indicated the resident was documented as having seven physically aggressive behaviors and three refusals of care or medications. In May the resident was documented as having five physically aggressive behaviors and 0 refusals of medications or treatments. Review of the initial facility psychiatric evaluation, completed on 07/22/11, indicated the physician discontinued the Zyprexa, increased the antidepressant, Cymbalta, and added another antidepressant, Buspar 15 mg twice a day. Interview with Social service staff member #10, on 11/03/11 at 11:45 A.M. indicated the facility corporation liaison in another city had completed the pre-admission assessment for Resident #31 and the facility had no documentation of the information or assessment completed. She indicated she was not really sure what the antipsychotic medications the resident had been admitted to the facility with were specifically to treat. She indicated all she knew prior to Resident #31's admission was that he had previously been rejected for admission due to his behavior issues			

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	and later was accepted. She indicated a behavior tracking form had not been initiated on admission because she was unsure what the behaviors the resident displayed were going to be and the resident did not exhibit behaviors until April 2011. Review of the health care plans for Resident #31 indicated a plan to address the resident's refusal of medications, initiated on 04/11/11, with interventions to educate the resident on the reason and consequence of not taking the medication, encourage the resident to take his medications, inform the physician of the resident's refusal, reapproach later, and use a calm approach from the front. A plan to address the resident's "Ineffective coping; physical aggression and verbal aggression" included the following interventions, all initiated on 03/31/11: administer psych meds as ordered and monitor side effects on appropriate tracking form, allow resident time to respond to directions or request, approach the resident slowly and from the front, be cognizant of not invading resident's personal space, be sure you have the resident's attention before speaking or touching, do not make unrealistic demands on resident, and give resident choices in care. One additional			

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	intervention, reapproach later, was added on 06/28/11. Another plan, initiated on 10/31/11, addressed the resident's inappropriate physical behavior issues such as yelling, hitting, kicking, pinching staff during care. The interventions included: Administer psych meds, document physical behavior with staff interventions such as 1) slow approach from the front and allow him to respond 2) give choice, regarding care 3) reapproach later 4) approach with alternate staff member, monitor medication side effects, notify physician as needed, psych services to follow resident as needed. A physician's order, dated 10/22/11 increased the resident's Risperdone to .5 mg three times a day. However, review of the August, September, and October 2011 behavior tracking indicated there had actually been an improvement in response to interventions to behaviors in September and a decrease in behaviors in October 2011. Interview with SS staff member #10, on 11/03/11 at 11:45 A.M. indicated the resident had refused to see the psychiatrist in August, but the paper work for all three months was sent with the resident in October and the psychiatrist utilized the Behavior tracking tally and the progress notes to treat the resident's			

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	condition as it was in August and September. There was no coordination in care provided to assist this resident with adjustment issues and behaviors with adjusting to his new environment. Nor did staff timely address and individualize his care plans to his specific needs. 3.1-34(a)			
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to revise care plans to address needs for 2 of 8 residents reviewed with behaviors (Residents #31, 68) and 1 of 5 residents reviewed with falls (Resident #19) in a total sample of	F0280	This facility has a system in place, along wtih policies & procedures, to ensure the right for residents to participate in care planning & care plans will be revised in accordance with significant needs. Residents 31, 66, & 19 have had their individual	12/03/2011

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	21. Findings include: 1. During the initial tour of the facility, conducted on 10/31/11 between 10:30 A.M. - 11:30 A.M., the Assistant Director of Nursing indicated Resident #31 was nonverbal or had very slurred speech, had experienced a stroke in the past, and required extensive staff assistance for activities of daily living. Resident #31 was observed on 11/01/11 at 1:00 P.M., propelling himself slowly in a wheelchair around the facility. The resident was noted to nod his head when asked questions by staff passing him in the hallway. The clinical record for Resident #31 was reviewed on 11/02/11 at 10:30 A.M. Resident #31 was admitted to the facility from another long term care facility on 03/22/11, with diagnoses including, but not limited to, behavioral disturbance, cognitive impairment, and late effect CVA (cerebral vascular accident). The resident's admitting physician's order, included the medications, Risperdone (an antipsychotic) 0.5 mg twice a day, Diavaproex sodium (an anticonvulsant used as a mood stabilizer) 500 mg twice a day, Risperdal consta (an antipsychotic)		care plans reviewed & updated. These residents did not suffer any negative effects as a result of this finding. All residents residing in this facility have the potential to be affected by this finding. To ensure future compliance, this facility has a system in place whereby significant changes, unusual occurences, & new physician orders are reviewed daily during staff meetings & by daily review of the 24 hour condition report tool. During this review, any necessary changes to the care plan will be completed & interventions will be implemented. Staff members will be made aware of these interventions via the nursing assistant assignment sheet & via shift report. Monitoring of this system will be completed weekly for 90 days by using the 24 hour condition report tool contained in the facility Quality Assurance program (Attachment B). After 90 days, this audit will continue monthly per the existing Quality Assurance program calendar.	

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	25 mg IM (intramuscularly) once every 14 days, zyprexa zydis (an antipsychotic) 5 mg once a day, Cymbalta (an antidepressant) 60 mg once a day, and oxycontin (a pain medication) 20 mg twice a day. Review of the resident's Minimum Data Set (MDS) from 8/9/11 for a significant change, indicated the resident had moderately impaired cognition and had behaviors of being physically and verbally abusive. The resident also exhibited symptoms of depression. Review of nursing progress notes, dated 04/04/11 indicated the resident had gotten very agitated with staff during care and had cursed and swung at staff. The note also indicated the resident had refused a medication three days in a row and would get very angry when approached with the medication. Nursing note on 04/07/11 indicated the resident was refusing incontinence care. On 04/08/11 Resident #31 became agitated with another resident and yelled and shook his finger at the resident. He was also refusing assistance with dressing, despite staff attempts at reapproaching him later. On 04/14/11 social service staff spoke			

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	with the resident's spouse about the need to see a psychiatrist to manage the resident's psychiatric medications. She requested a specific, local psychiatrist who had previously seen the resident. On 04/15/11 the resident swore loudly in the dining room, but was unable to verbalize what had upset him. On 04/16/11 the resident had refused to get up and had refused care. A nursing progress note, dated 04/18/11 indicated the resident's wife had indicated the resident could be left in bed for breakfast because this had been his routine prior to admission to this facility. On 04/21/11 the resident refused all of his medications and different nursing staff were unable to convince the resident to take his medication. The resident's wife came in later in the day and did convince him to take his medications. On 04/22/11 the resident refused his morning medications and pointed his finger at staff. On 04/26/11 the resident's spouse was informed of the psychiatric appointment scheduled for 05/04/11 with the psychiatrist she had requested.			

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	On 05/24/11 the resident's spouse was informed of the next psychiatric appointment scheduled for 06/01/11 and she indicated she could not accompany the resident to the appointment. On 05/31/11 the social service staff spoke to the resident's spouse about changing the resident's psychiatrist to the facility's psychiatrist due to the spouse's inability to accompany her husband to appointments at the outside psychiatrists' office. The 06/01/11 appointment was canceled. On 06/09/11 the wife's spouse was asked to complete paperwork for the facility's psychiatrist. On 06/12/11 and 06/14/11 the resident refused treatments and/or medications. On 06/18/11 the resident had refused medications and started yelling and grabbed staff's arm during treatment of his wounds. The resident also refused to get up for lunch. On 06/20/11 the resident refused his medications and had also yelled at staff during wound treatments. On 06/22/11 the resident swore at staff and refused to allow staff to treat his			

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	wounds. On 06/23/11 the resident refused mediations. The resident also had refused to allow the wound center to treat his wounds and refused to allow facility staff to treat his wounds. On 06/24/11 the resident became combative and yelled when staff tried to provide incontinence care and get the resident up for the evening meal. On 06/25/11 the resident refused his morning medications and treatments. On 06/26/11 and 06/27/11 the resident refused his morning medications. On 06/30/11 the resident struck a CNA providing care for him. Review of the April behavior monitoring records indicated the resident was documented as having seven physically aggressive behaviors and three refusals of care or medications. In May the resident was documented as having five physically aggressive behaviors and 0 refusals of medications or treatments. Review of the initial facility psychiatric evaluation, completed on 07/22/11, indicated the physician discontinued the			

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	Zyprexa, increased the antidepressant, Cymbalta, and added another antidepressant, Buspar 15 mg twice a day. Interview with Social service staff member #10, on 11/03/11 at 11:45 A.M. indicated the facility corporation liaison in another city had completed the pre-admission assessment for Resident #31 and the facility had no documentation of the information or assessment completed. She indicated she was not really sure what the antipsychotic medications the resident had been admitted to the facility with were specifically to treat. She indicated all she knew prior to Resident #31's admission was that he had previously been rejected for admission due to his behavior issues and later was accepted. She indicated a behavior tracking form had not been initiated on admission because she was unsure what the behaviors the resident displayed were going to be and the resident did not exhibit behaviors until April 2011. Review of the health care plans for Resident #31 indicated a plan to address the resident's refusal of medications, initiated on 04/11/11, with interventions to educate the resident on the reason and consequence of not taking the medication, encourage the resident to take his			

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	medications, inform the physician of the resident's refusal, reapproach later, and use a calm approach from the front. A plan to address the resident's "Ineffective coping; physical aggression and verbal aggression" included the following interventions, all initiated on 03/31/11: administer psych meds as ordered and monitor side effects on appropriate tracking form, allow resident time to respond to directions or request, approach the resident slowly and from the front, be cognizant of not invading resident's personal space, be sure you have the resident's attention before speaking or touching, do not make unrealistic demands on resident, and give resident choices in care. One additional intervention, reapproach later, was added on 06/28/11. Another plan, initiated on 10/31/11, addressed the resident's inappropriate physical behavior issues such as yelling, hitting, kicking, pinching staff during care. The interventions included: Administer psych meds, document physical behavior with staff interventions such as 1) slow approach from the front and allow him to respond 2) give choice, regarding care 3) reapproach later 4) approach with alternate staff member, monitor medication side effects, notify			

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	physician as needed, psych services to follow resident as needed. A physician's order, dated 10/22/11 increased the resident's Risperdone to .5 mg three times a day. However, review of the August, September, and October 2011 behavior tracking indicated there had actually been an improvement in response to interventions to behaviors in September and a decrease in behaviors in October 2011. Interview with SS staff member #10, on 11/03/11 at 11:45 A.M. indicated the resident had refused to see the psychiatrist in August, but the paper work for all three months was sent with the resident in October and the psychiatrist utilized the behavior tracking tally and the progress notes to treat the resident's condition as it was in August and September. There was no coordination in care provided to assist this resident with adjustment issues and behaviors with adjusting to his new environment. Nor did staff timely address and individualize his care plans to his specific needs. 2. During the initial tour of the facility, conducted on 10/31/11 between 10:30 A.M. - 11:30 A.M., the Assistant Director of Nursing indicated Resident #68 was confused and had recently been			

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	hospitalized for pneumonia. The clinical record for Resident #68 was reviewed on 10/31/11 at 2:30 P.M. Resident #68 was admitted on 06/02/11 with diagnosis, including but not limited to anxiety, senile dementia, and COPD (chronic obstructive respiratory disease). Review of nursing progress notes, dated 06/18/11 at 17:52 (5:52 P.M.) indicated the following: "resident called husband twice today, asking for him to come pick resident up due to resident needing a quick cigarette. Resident got worked up, received an anxiety pill, then called and left message for daughter to come pick resident up. writer was able to distract resident to dining area for supper." A nursing progress note, dated 06/19/11 at 10:52 A.M. indicated the following: "resident assisted with phone call to husband as she required. Resident anxious, stated ' I'm going home today somehow'. Came out of room to writer several times this AM wanting pills to take home with her and to call her husband again. Resident stated 'I'm getting anxious.' Resident requesting something for her anxiousness. Resident medicated with Xanax (an antianxiety medication) .25 mg which was helpful...."			

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	Review of progress notes from 06/20/11 - 07/12/11 indicated the following behavior issues: 06/20/11 18:53 (6:53 P.M.) "...entered another resident's room and took blanket off the bed. ...Resident began yelling at the other resident when confronted about taking the blanket....Later in shift, resident became aggressive with a CNA (certified nursing assistant) while she was helping her get ready for bed...resident hit CNA in the left arm with a closed fist...." 06/21/11 15;16 (3:16 P.M.) "...sitting by exit door waiting for family to come. resident had belongings wrapped in blanket...given Xanax at 9:30 A.M., Resident did calm down...." 06/22/11 21:51 (9:51 P.M.) "Resident became upset with another resident his shift. Another resident was sitting in the hallway and was yelling out. Resident came up to the yelling resident and said 'If you don't stop yelling I'll shove this banana down your throat.' The residents were quickly separated and the resident was redirected into her room." 06/23/11 13:40 (2:40 P.M.) "Resident has had increased confusion and agitation during shift...has continued to pack belongings and then put everything on the edge of her bed and in the middle of the			

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	floor. Resident spent most of the day attempting to leave. Resident requested several times to call family....Resident also attempted to eat oatmeal out of her bowl with a straw during breakfast. Wanderguard is being placed on resident...." 06/24/11 11:05 A.M. "Resident has been pulling her dressing off of her left forearm. Resident stated 'I'm going to hurt you if it gets infected.'" The resident was sent to the hospital on 06/25/11 for respiratory issues and readmitted to the facility on 07/03/11. 07/03/11 18:37 (6:37 P.M.) "Resident picking at scab on left forearm stating that 'maggots and bugs are crawling on my arm.' Attempted to apply geri sleeve as nursing measure to prevent resident from picking at scab. Resident then sated (sic) 'I'm gong to claw you in your eyes.' She then made physical contact with staff nurses eye. Writer tried to reapproach resident and multiple staff members also tried to approach resident. Snack and fluids were also offered to resident. Due to all other interventions failing resident was given 0.25 mg of xanax at 6:45 P.M." 07/03/11 21:16 (9:16 P.M.) "Resident continues to yell out and at staff after			

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	receiving xanax. Staff has asked resident to express feelings and her concerns but resident stated 'You don't care about me" TV was also turned on in room. Resident was then offered to use the restroom by staff and she then unfastened her incontinence brief and began to pee in a cup from her bedside table and stated, 'I'm going to pour this on my arm, this should kill the maggots.' Writer retrieved the cup of urine from the resident and disposed of it...." 07/09/11 21:16 (9:16 P.M.) "Resident came out of room requesting to call her husband so that he could come pick her up so she could help at the farm tomorrow. Writer called her husband, but there was no answer. Resident then requested to call her son. Writer called her son but again, there was no answerer...Resident again requested to call her husband and son...Resident then wheeled herself down to the rehab nursing station and tried to use that phone to call. When the rehab nurse tried explaining to her that she was waiting for a doctor to call her and didn't want to tie up the phone, resident tried hitting the rehab nurse. Resident then requested to go to the kitchen to see if her husband was there so writer took her to the kitchen. Resident then wanted to use that phone to call her husband again. When writer			

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	explained that we could go down to the nurse's station to call, resident tried hitting writer...." 07/10/11 1:22 P.M. "...resident had packed all her belongings in a plastic bag and stated this time when she leaves she is not coming back to this place...stated that everyone around here was mean to her cause they won't help her get her stuff ready for home an allow her to call her family to come get her. Resident was given her prn (per requested need) anxiety pill...." 07/11/11 9:40 A.M. "resident was eating breakfast at her table in the DR (dining room)...when tablemate's husband approached table to talk to tablemate and say hello, this resident looked at tablemate's husband and had a verbal outburst toward the gentleman, using some words of profanity. CDM (certified dietary manager) approached resident as she finished her sentence (sic) and explained to resident that the DR is a publuc (sic) area, that no one is trying to take her seating arrangement from her and that other residents have ea right to eat at the same table as her. This resident then yelled profanity at the CDM...." 07/11/11 10:27 A.M. "Resident has been yelling at staff to call family. writer has			

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	assisted resident with calling all three contacts and resident is demanding to go home. Writer with other staff members have redirected resident multiple times and all of the interventions were unsuccessful writer has medicated resident with prn anxiety medication and also with prn pain medications as of this time resident is sitting at the nurses station with writer and continues to yell." 07/11/11 14:15 P.M. (2:15 P.M.) "Resident was sitting in the lobby wanting to go outside while being redirected by staff resident tried to hit staff member. Then resident was slowly approached by another staff member and resident go a hold of staff members hair two staff members helped to get resident o let go of staff member...." A physician's order was received on 07/11/11 for xanax (an antianxiety medication) to be give three times a day routinely and to obtain a psychiatric evaluation. On 07/12/11 the resident's husband was contacted by the social service staff regarding the need to place the resident in an inpatient psychiatric hospital. On 07/12/11 at 15:38 (3:38 P.M.), the resident was yelling at staff and hit staff.			

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	She was medicated with xanax. On 07/12/11 at 17:29 P.M., the resident was transported to the psychiatric hospital. Review of the care plans addressing behaviors for Resident #68, indicated a plan to address "wandering" initiated on 06/23/11 with interventions to allow the resident to wander, check daily to ensure the wanderer's bracelet was on, have family place familiar object in room, provide direction cues, and allow to call husband/son. There was also a plan to address "resident wander around facility and attempts to get out of the exit doors", initiated on 06/23/11 with interventions to check the placement of the wanderguard every shift and daily for function and apply wanderguard to wheelchair. Finally, there was a plan to address the resident's "Ineffective coping" initiated on 06/24/11 with interventions to move to quiet environment, approach the resident slowly and from the front, be cognizant of not invading resident's personal space, and discuss resident's options for appropriate channeling of anger with resident, and reapproach later." Despite the resident's increasingly aggressive behavior and hallucinatory behavior, the ineffectiveness of the			

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	current interventions, the care plans addressing behaviors were not updated with individualized interventions. 3. Resident #19's record was reviewed 11-2-11 at 1:35 p.m. Resident #19's diagnoses included but were not limited to coronary artery disease, obesity and stroke. Nursing documentation dated 9-21-2011 at 10:45 p.m. indicated Resident #19 had fallen in the room next to the wheelchair. An interview with Resident #19 conducted by the nursing staff at the time of the fall indicated he had fallen while transferring. A review of the post fall investigation dated 9-21-2011 at 10:45 p.m. indicated Resident #19 had been transferring from the wheelchair into the reclining chair when the fall occurred. The investigation further indicated the wheel chair wheels had not locked tightly. Interventions listed on the investigation form included rearranging items to give the resident more room to transfer, changing wheelchairs until the brakes could be fixed, referral to therapy and staff to check and offer assistance (the form did not include frequency). A current fall risk care plan dated 10-8-2007 and updated 6-2-2011			

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	indicated to keep pathways clear, but did not include fixing the wheel chair brakes, or staff to check and offer assistance. In an interview on 11-3-2011 at 1:25 p.m., LPN#2 indicated fall interventions were to be updated on the care plan at the time of the fall or whenever the fall review committee meets to review the fall. A current policy dated 11-2-2010 titled Care Plan Development and review indicated the care plan is developed in conjunction with the Minimum Data Set and revised daily and as necessary as changes dictate. 3.1-35(d)(2)(B)			
F0282 SS=D	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 follow physician's orders for one resident (#80) of 21 residents reviewed for physician's orders and failed to follow a health care plan for fall interventions for one resident (#96) of 21 residents reviewed for health care plans in a sample of 21 residents. Findings include:	F0282	This facility has a system in place, along with policies & procedures, to provide comprehensive care plans for all residents. Both residents 80 & 96 did not suffer any negative consequences as a result of this finding. Both residents have had their individual care plans reviewed & updated as necessary with additional supplies as needed or changes in the identified environmental needs. This finding has the potential to	12/03/2011

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	1. Resident #80's record was reviewed on 11/2/11 at 10:15 A.M.. The record indicated the resident received a physician's order to wear knee high TED hose bilateral on 10/10/11. Resident #80 was observed on 11/2/11 at 12:30 P.M. eating lunch seated in a wheelchair without knee high TED hose on. The resident was observed on 11/2/11 at 4:30 P.M. sitting in his wheelchair in the hallway without wearing knee high TED hose. On 11/3/11 at 11:45 A.M. An interview with the LPN #3 on 11/3/11 at 11:50 A.M. indicated she did not know the reason why resident #80 had not been wearing TED hose on 11/2/11 and 11/3/11. An interview with the Director of Nursing (DN) on 11/3/11 at 1:35 P.M. indicated the resident's TED hose had been wet and staff washed them and were waiting for them to dry. The DN indicated a second pair of TED hose had been acquired for the resident. 2. Resident #80's record was reviewed on 11/2/11 at 10:15 A.M.. The record indicated on 10/26/11 the resident returned from a hospital with new physician's orders for three medications: Omnicef 300 milligrams (mg) twice daily		affect all residents residing in this facility. To ensure future compliance, a mandatory staff inservice was held on 11/22/11 to address care plan review ongoing. Care plan interventions are identified on the nursing assistant worksheets, report sheet, task lists, & this plan of correction will be posted internally within this facility. To monitor for ongoing compliance, health care plans will be reviewed at least every 90 days by the MDS & MDS Assistant. Any acute care plan information will be reviewed at least weekly by the assigned Unit Manager(s), Director of Nursing, Assistant Director of Nursing, & designated nursing staff. Care plans will be updated soon after the receipt of an order by the charge nurses & reviewed by the Unit Managers for accuracy & compliance within 48 hours of the receipt of an order. The Care Plan Record Review (Attachment C) will be utilized for this review ongoing. Any findings will be corrected upon discovery & a summary will be presented to the Quality Assurance committee monthly for review & to ensure future compliance.	

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	for seven days; reduce Trazadone to 25 mg at bedtime through 10/31/11 then discontinue; hold Lasix today, then go back to 20 mg each AM starting 10/27/11. Review of the resident's Medication Administration Records (MAR's) from October 2011 indicated the medication changes were correctly implemented. A review of the November 2011 MAR's on 11/2/11 at 10:15 A.M. indicated Trazadone was given on 11/1/11 at 8:00 P.M.. The Nov ember 2011 MAR did not include Omnicef 300 mg which should have been given twice on 11/1/11 and once on 11/2/11 at 8:00 A.M.. The November 2011 MAR indicated Lasix 40 mg to be given at 8:00 A.M. and was given on 11/1/11 and 11/2/11. An interview with LPN #1 on 11/2/11 at 10:20 A.M. indicated the Lasix which had been given to resident #80 on 11/1/11 and 11/2/11 was the correct dose of 20 mg and not the 40 mg indicated on the November MAR. 3. During the initial tour of the facility, conducted on 10/31/11 between 10:30 A.M. - 11:30 A.M., the Assistant Director of Nursing (ADON), indicated Resident #96 was confused, required extensive staff assistance for Activities of Daily Living, and had fallen in the past year and suffered an eye injury due to the fall.			

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	Resident #96 was observed during the tour seated in her room in a wheelchair. The resident had an alarm attached to the back of her shirt, her left hand was contracted, and her right eye appeared to be enucleated. Resident #96 was observed on 11/02/11 at 10:05 A.M., seated in her wheelchair in her room. The privacy curtain was partially pulled and obscured viewing the resident completely from the hallway. The resident was noted to be leaning forward in her wheelchair, pulling the alarm cord taunt, and almost resting her head on her bed. Her wheelchair was facing her bed. The resident indicated she was tired. The call light was pushed for the resident and staff were alerted. Resident #96 was observed on 11/02/11 at 1:25 P.M., seated in her wheelchair in her room, facing her recliner. The resident was again bent forward at the waist resting her head in her hands almost resting her head on her knees. The resident's alarm cord was again pulled taunt. Staff were alerted of the resident's condition and position and assisted the resident to her recliner where she immediately fell asleep. The clinical record for Resident #96 was reviewed on 11//01/11 at 1:30 P.M. The			

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	most recent Minimum Data Set, MDS, assessment for Resident #96, completed on 09/28/11, indicated she was nonambulatory and required extensive staff assistance for transferring and wheelchair mobility needs. The assessment also indicated the resident had experiences two falls with no injuries and 1 fall with injuries in the past 90 days. Review of the current health care plan for falls, current through 12/2011, included the following: Interventions: "resident to be in recliner after meals. Also encourage (resident's name) to lay down in afternoon if she is tired. Encourage resident to stay out of room unless she is in bed/recliner or getting assistance with ADL care by staff member...." 3.1-35(g)(2)			
F0314 SS=D	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 infection and prevent new sores from developing. Based on record review and interview, the facility failed to prevent development of a pressure sore for 1 resident (#99) of 7	F0314	It is the policy of this facility to prevent the development of pressure ulcers. Resident 99's	12/03/2011

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	residents reviewed for development of pressure ulcers in a sample of 21. Findings include: Resident #99's clinical record was reviewed on 11/1/11 at 2:20 P.M. The record indicated an "Incident/Accident Report and Investigation from 10/18/11 at 8:00 P.M. The description of the incident indicated, "Resident was on bedpan, CNA gave her call light and left room for privacy, resident heard yelling out, when staff entered room and took off bedpan, noted open area to coccyx measures 0.2 x 0.2 cm" (centimeters). A resident interview on the Incident/Accident report indicated: "I had my call light in my hand, but I couldn't push the button." Review of the facility's self reported incident dated 10/20/11 indicated "CNA put resident on bedpan and left call light with resident. Resident normally will turn on call light and uses the call system appropriately. CNA went about caring for other residents and forgot resident was on bedpan. The resident was on the bedpan for approximately 1.75 hours." On 10/18/11 a physician's order was received to start Sensicare cream to pressure ulcer on coccyx until healed.		pressure ulcer at the time of discovery was identified as a superficial stage 2 ulcer. This pressure area was healed quickly without any complications. All residents residing in this facility have the potential to develop pressure ulcers. To ensure future compliance, all residents will receive a complete head to toe skin assessment weekly by a licensed nurse. Any new skin areas found will be immediately assessed, physician & responsible party will be notified, & appropriate treatment will be initiated. If the skin area is identified as a pressure area, the aforementioned will apply & further notification will be given to the Wound Nurse, who will either make a new assessment at that time or will concur with the initial assessment. At a minimum thereafter until the area is healed, the pressure area will be assessed weekly & documentation, not limited to but including status & stage will be completed. In addition, as warranted by facility policy, the pressure area will be assessed & monitored or treated by the facility contracted Wound Physician, or by the residents attending physician. All pressure areas will be reviewed weekly during facility quality of life meetings by the assigned Wound Nurse, MDS Coordinator, Dietary Manager, Director of Nursing, and or designee to review status & stage	

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	An interview with the wound nurse, the Assistant Director of Nursing (ADN) on 11/2/11 at 3:00 P.M. indicated the resident's pressure ulcer was healed on 10/25/11. 3.1-40(a)(1)		& any appropriate treatment. Nursing staff have been re-educated related to the importance of skin care & use of appliance that may affect skin, i.e. - use of bed pans, etc. To ensure future compliance, any resident(s) who currently uses a bed pan will be checked at no less than 15 minute intervals while in use. Furthermore, residents will be encouraged to utilize the toilet facilities whenever possible. The audit tool entitled "Pressure Ulcer Risk Reduction & Treatment Review" (Attachment D) will continue to be completed monthly by the DON, or designee. Any findings will be reviewed at the monthly Quality Assurance meeting for correction or change in plan of care.	

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F0329 SS=D	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 observations, record review, and interview, the facility failed to ensure there was adequate monitoring and documentation to support a medication increase for 1 of 8 residents reviewed for psychotropic medications in a sample of 21. (Resident #31) Finding includes: During the initial tour of the facility, conducted on 10/31/11 between 10:30 A.M. - 11:30 A.M., the Assistant Director of Nursing indicated Resident #31 was nonverbal or had very slurred speech, had experienced a stroke in the past, and	F0329	Resident 31's antipsychotic medication use has been reviewed with the psychiatric services team & the medication prescribed has been determined to be medically necessary for this resident based upon past behavioral history & present state of health. During the admission process, the transferring facility was only able to release information to the admitting facility based upon the previous stay at a transferring facility, so no additional information regarding psychiatric history from previous medical providers. Resident 31 suffered no negative consequences as a result of this current psychoactive medication	12/03/2011

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	required extensive staff assistance for activities of daily living. Resident #31 was observed on 11/01/11 at 1:00 P.M., propelling himself slowly in a wheelchair around the facility. The resident was noted to nod his head when asked questions by staff passing him in the hallway. The clinical record for Resident #31 was reviewed on 11/02/11 at 10:30 A.M. Resident #31 was admitted to the facility from another long term care facility on 03/22/11, with diagnoses including, but not limited to, behavioral disturbance, cognitive impairment, and late effect CVA (cerebral vascular accident). The resident's admitting physician's order, included the medications, Risperdone (an antipsychotic) .5 mg twice a day, Diavaproex sodium (an anticonvulsant used as a mood stabilizer) 500 mg twice a day, Risperdal consta (an antipsychotic) 25 mg IM (intramuscularly) once every 14 days, zyprexa zydis (an antipsychotic) 5 mg once a day, Cymbalta (an antidepressant) 60 mg once a day, and oxycontin (a pain medication) 20 mg twice a day. Review of the initial facility psychiatric evaluation, completed on 07/22/11 indicated the physician discontinued the		regimen. Any resident receiving a psychotropic medication has the potential to be affected by this finding. To ensure that psychoactive medications, including anti-psychoactive medications, are being used appropriately to treat identified behaviors & diagnoses, a monthly medication review will be completed by the pharmacy consultant, Social Services department staff, & Director of Nursing. A review of the status of medication use, & associated behaviors, will be completed & reviewed by the Health Care plan team. All staff members have been made aware of the facility policy for the use of psychoactive medications, including prompt notification of the Social Services department, when new medications are ordered by the physician. This system will be monitored monthly by the Social Services Director & Social Services Assistant using the Behavior & Antipsychotic Medication Review Quality Assurance tool (Attachment A). All residents who receive psychoactive medications will be reviewed monthly ongoing. Any findings will be reported as need be at the Quality Assurance committee meeting ongoing & corrections will be made as needed at the time of discovery.	

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	Zyprexa, increased the antidepressant, Cymbalta, and added another antidepressant, Buspar 15 mg twice a day. Interview with Social service staff member #10, on 11/03/11 at 11:45 A.M. indicated the facility corporation liaison in another city had completed the pre-admission assessment for Resident #31 and the facility had no documentation of the information or assessment completed. She indicated she was not really sure what the antipsychotic medications the resident had been admitted to the facility with were specifically to treat. She indicated all she knew prior to Resident #31's admission was that he had previously been rejected for admission due to his behavior issues and later was accepted. She indicated a behavior tracking form had not been initiated on admission because she was unsure what the behaviors the resident displayed were going to be and the resident did not exhibit behaviors until April 2011. A physician's order, dated 10/22/11 increased the resident's Risperdone to .5 mg three times a day. However, review of the August, September, and October 2011 behavior tracking indicated there had actually been an improvement in response to interventions to behaviors in September			

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	and no behaviors documented as of 10/22/11 in October 2011. Interview with SS staff member #10, on 11/03/11 at 11:45 A.M. indicated the resident had refused to see the psychiatrist in August, but the paper work for all three months was sent with the resident in October and the psychiatrist utilized the behavior tracking tallies and the nursing progress notes to treat the resident's condition as it was in August and September. She thought perhaps there were more behavior issues documented in the progress notes in October 2011 but no documentation was provided to support the increase in the Risperdone. 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)			
F0371 SS=F	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, record review, and interview, the facility failed to assure an insect problem (infestation) in the kitchen was addressed in a timely manner to ensure food was prepared and served under sanitary conditions. This	F0371	The source of the flying insect problem was located on 11/1/11 & mechanical repairs were made to resolve this issue. In addition, the kitchen dish room has been cleaned thoroughly to ensure a sanitary environment. Staff have been making daily rounds in the	12/03/2011

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	potentially affected all of the residents in the facility. Findings include: During group meeting with the residents, beginning at 10:00 a.m. on 11/1/11, 2 of 11 residents attending the group meeting, Residents #2 and #8, indicated within the last two weeks, they had observed "gnats" in or on their food. During the initial tour of the Kitchen, beginning at 10:25 a.m., on 10/31/11, and accompanied by the Dietary Manager, small insects were noted to be in scattered areas on the ceiling and walls of the Dishwasher room. They were too numerous to count, but the Dietary Manager indicated there were definitely fewer of them than when the problem had started over a month ago. There were a fewer number of the insects , approximately 15-20 observed on the walls and ceiling in the main kitchen area, outside of the Dishwasher room, but none were observed around the food service area where the food was being prepared. The Dietary Manager indicated the insects were "gnats" and they had started appearing over a month ago, and the exterminator had come to the facility and had treated the area where the gnats were located.		dishroom to focus on the elimination of the flying insects. The facility staff were previously unaware of any resident concerns with gnats or flying insects being on or in food items. All residents have the potential to be affected by this finding. Our contracted pest control service will continue to inspect & treat the facility monthly with an added emphasis to monitor & treat the kitchen dish room as need be ongoing. A Dietary Food Safety Sanitation Checklist (Attachment E) will be utilized weekly for 4 weeks, then monthly thereafter, to monitor for flying insects in the kitchen dish room area as part of the facilty Quality Assurance Program to ensure future compliance. The Dietary Manager, or designee, will oversee & monitor this checklist ongoing.	

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	A bug light with glueboard was observed on the wall in the dishwasher room, and the Dietary Manager indicated the exterminator had hung the bug light to help catch the gnats. Two pest control service reports, provided by the Dietary Manager, at 11:30 a.m., on 10/31/11, were reviewed. The first one, dated 9/12/11, indicated an insecticide was used in the entryways, kitchens, common areas, shower rooms, utility, laundry, and several resident rooms for pavement ants. The report also indicated "glueboards" were used, but didn't indicate the location of the glueboards. The second pest control report, dated 10/10/11, indicated a different insecticide was used for insect control in the entryways, shower rooms, dining room, breakroom, and several assisted living rooms. The Dietary Manager indicated the problem with the gnats was aggressively addressed by the exterminator, and he had sprayed the dishwasher room on both visits, but on 10/20/11, the gnat problem started getting worse. She indicated the Dietician visited on 10/20/11, and when she visited again on 10/24/11, the situation with the gnats had improved.			

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	At 9:15 a.m., on 11/1/11, 2 men were observed working on the wall in the main dining room, near the entrance to the kitchen, and an opening was noted in the wall. The Administrator was interviewed, at 2:10 p.m., on 11/1/11, and indicated the problem with the insects had started over a month ago, and the pest control man had visited twice to address the problem. The Administrator indicated he had contacted the pest control company on 10/31/11, and the supervisor of the pest control company had visited the facility on the afternoon of 10/31/11, regarding the insect problem. The Administrator indicated the supervisor of the pest control company could not identify the type of insect, but had written a note regarding the insect problem, and documented the insect was a "fruit fly. " The Administrator indicated the pest control supervisor had placed 3 canisters in the dishwasher room to attract the insects when he visited on the afternoon of 10/31/11. A written statement, dated 10/31/11, and signed by a representative from the pest control company, indicated, "was in today to look at the fruit fly problem in the kitchen. We are going to bring in			

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	some traps to help with control. " The Administrator also indicated he had contacted the Maintenance Consultant from corporate and he had visited the facility on the morning of 11/1/11 regarding the insect problem. He indicated the Maintenance Consultant had removed a panel from the wall in the main dining room in order to get behind the dishwasher. The Administrator indicated the Maintenance consultant had found the source of the insect problem along a crack which had developed between the wall and floor behind the dishwasher.			
F0469 SS=F	3.1-21(i)(3) 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 assure an insect problem (infestation) in the kitchen was addressed in a timely manner. This potentially affected all of the residents in the facility. Findings include: 1. During the initial tour of the Kitchen, beginning at 10:25 a.m., on 10/31/11, and accompanied by the Dietary Manager, small insects were noted to be in scattered areas on the ceiling and walls of the	F0469	The source of the flying insect problem was located on 11/1/11 & mechanical repairs were made to resolve this issue. In addition, the kitchen dish room has been cleaned thoroughly to ensure a sanitary enironment. Staff have been making daily rounds in the kitchen dish room to focus on the elimination of the flying insects. The facility staff were previously unaware of any resident concerns with gnats or flying insects being in or on food items. All residents have the potential to be affected by this finding. Our contracted pest control service will continue to inspect & treat the facility	12/03/2011

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	Dishwasher room. They were too numerous to count, but the Dietary Manager indicated there were definitely fewer of them than when the problem had started over a month ago. There were a fewer number of the insects , approximately 15-20 observed on the walls and ceiling in the main kitchen area, outside of the Dishwasher room, but none were observed around the food service area where the food was being prepared. The Dietary Manager indicated the insects were "gnats" and they had started appearing over a month ago, and the exterminator had come to the facility and had treated the area where the gnats were located. A bug light with glueboard was observed on the wall in the dishwasher room, and the Dietary Manager indicated the exterminator had hung the bug light to help catch the gnats. Two pest control service reports, provided by the Dietary Manager, at 11:30 a.m., on 10/31/11, were reviewed. The first one, dated 9/12/11, indicated an insecticide was used in the entryways, kitchens, common areas, shower rooms, utility, laundry, and several resident rooms for pavement ants. The report also indicated "glueboards" were used, but didn't indicate the location of the glueboards.		monthly with an added emphasis to monitor & treat the kitchen dish room as need be ongoing. The Dietary Food Safety Sanitation Checklist (Attachment E) will be utilized weekly for 4 weeks, then monthly thereafter, to monitor for flying insects in the kitchen dish room area as part of the facility Quality Assurance Program to ensure future compliance. The Dietary Manager, or designee, will oversee & monitor this checklist ongoing.	

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	The second pest control report, dated 10/10/11, indicated a different insecticide was used for insect control in the entryways, shower rooms, dining room, breakroom, and several assisted living rooms. The Dietary Manager indicated the problem with the gnats was aggressively addressed by the exterminator, and he had sprayed the dishwasher room on both visits, but on 10/20/11, the gnat problem started getting worse. She indicated the Dietician visited on 10/20/11, and when she visited again on 10/24/11, the situation with the gnats had improved. At 9:15 a.m., on 11/1/11, 2 men were observed working on the wall in the main dining room, near the entrance to the kitchen, and an opening was noted in the wall. The Administrator was interviewed, at 2:10 p.m., on 11/1/11, and indicated the problem with the insects had started over a month ago, and the pest control man had visited twice to address the problem. The Administrator indicated he had contacted the pest control company on 10/31/11, and the supervisor of the pest control company had visited the facility on the afternoon of 10/31/11, regarding			

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	the insect problem. The Administrator indicated the supervisor of the pest control company could not identify the type of insect, but had written a note regarding the insect problem, and documented the insect was a "fruit fly. " The Administrator indicated the pest control supervisor had placed 3 canisters in the dishwasher room to attract the insects when he visited on the afternoon of 10/31/11. A written statement, dated 10/31/11, and signed by a representative from the pest control company, indicated, "was in today to look at the fruit fly problem in the kitchen. We are going to bring in some traps to help with control. " The Administrator also indicated he had contacted the Maintenance Consultant from corporate and he had visited the facility on the morning of 11/1/11 regarding the insect problem. He indicated the Maintenance Consultant had removed a panel from the wall in the main dining room in order to get behind the dishwasher. The Administrator indicated the Maintenance consultant had found the source of the insect problem along a crack which had developed between the wall and floor behind the dishwasher. During group meeting with the residents,			

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	beginning at 10:00 a.m. on 11/1/11, 2 of 11 residents attending the group meeting, Residents #2 and #8, indicated within the last 2 weeks, they had observed "gnats" in or on their food.			
	3.1-49(f)(4)			
F0514 SS=A	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to completely document the results of a mantoux tuberculin test for 1 of 21 residents reviewed for tuberculin test documentation in a sample of 21. (Resident #47) Findings include: Resident #47's record was reviewed 11-1-2011 at 2:30 p.m. Resident #47's diagnoses included but were not limited to chronic lung disease, diabetes, and inflammatory disease of the bronchioles. A review of the Medication	F0514	Resident 47 received an annual Mantoux test in September 2011. Results were recorded on the MAR as negative, but the documentation of results in mm's was inadvertently omitted. The licensed nurse who read the results of the Mantoux test indicated that there was no induration. Appropriate re-education was completed with the identified nurse & the resident did not suffer any negative consequences as a result of this omission in documentation. In order to validate the negative 0.0mm result, a repeat Mantoux test was completed during the first week of November 2011 & the results confirmed a reading of 0.0mm of induration. All residents	12/03/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/03/2011
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	Administration record dated September 2011 indicated a tuberculin mantoux test had been administered on 9-27-2011 at 1 p.m. The record further indicated the test had been read on 9-30-2011 at 9 a.m. There was no indication of the results of the test (mm of induration or negative). In an interview on 11-2-2011 at 3:45 p.m., the Director of Nursing indicated there was no further documentation of the results of the mantoux. She indicated the nurse who read the test had indicated the test was negative but did not document the results. The Director if Nursing further indicated although there was no specific policy for tuberculin testing, the nurse should have documented the results. 3.1-50(a)(1)		who receive Mantoux testing have the potential to be affected by this finding. To ensure future compliance, all licensed nurses were re-educated during the first week of November 2011 to document Mantoux results in mm's of induration. All current resident records were reveiwed to ensure that this documentation is present. To monitor the effectiveness of this education & to ensure that results are documented correctly, an audit of at least 5% of the resident population will be conducted monthly using the Immunization Review (Attachment F) to verify that documentation is appropriate & accurate. Monitoring will be completed by the Medical Records Desginee & results will be presented monthly at the facility Quality Assurance committee meeting. Any necessary corrections will be completed immediately at the time of discovery.	