

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for a Recertification and State Licensure survey. This visit included Investigation of Complaint IN00151928.</p> <p>Complaint Number: IN00151928 Substantiated. Federal/state deficiencies related to the allegations are cited at F441 and F465.</p> <p>Survey dates: July 15, 16, 17, 21, 22, 2014</p> <p>Facility Number: 000234 Provider Number: 155342 AIM Number: 100273490</p> <p>Survey Team: Barbara Fowler, RN TC Diane Hancock, RN Dense Schwandner, RN Diana Perry, RN Anna Villain, RN</p> <p>Census Bed Type: SNF/NF: 61 Total: 61</p> <p>Census Payor Type: Medicare: 8 Medicaid: 42</p>	F000000	The preparation and/or execution of this plan of correction does not constitute agreement or admission by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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

TITLE

(X6) DATE

Any 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000242 SS=D	<p>Other: 11 Total: 61</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on July 28, 2014 by Jodi Meyer, RN</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident dietary preferences were honored, in that 2 residents received food that were on their dislikes list for dietary and additional resident that did not like her shirt. (Resident #63, Resident #24, Resident #47)</p> <p>Findings include:</p> <p>1. During an observation on 7/17/14 at</p>	F000242	It is the policy of Mt Vernon Nursing and Rehab Center to ensure that the residents' dietary preferences are honored. All staff will be re-in-serviced regarding providing the personal choices for each resident as it is recorded from their personal preferences upon assessment. After each meal, the cook/aide will randomly select 2 residents for a brief satisfaction survey of their meal. This will provide better communication between the nutrition staff and the residents and offer the residents more practice with personal	08/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>12:20 p.m., Resident #63 was observed to be sitting in a recliner with her lunch tray. Resident #63 was observed to be eating a ham salad sandwich. Resident #63 indicated the ham salad had pickles in it. The tray identification ticket indicated Resident #63 was to have no ham, ham salad, or pickles.</p> <p>During an interview on 7/17/14 at 12:20 p.m., Resident #63 indicated she did not really like ham salad. Resident #63 indicated she received foods that she dislikes often.</p> <p>The clinical record for Resident #63 was reviewed on 7/17/14 at 2:45 p.m. Resident #63 was on a controlled carbohydrate with no added salt diet. Resident #63 had a BIMS (Brief Interview of Mental Status) assessment score of 15, indicating no cognitive impairment.</p> <p>2. During an observation on 7/17/14 at 12:28 p.m., Resident #24 was observed to be in her room with her lunch tray. Resident #24 was observed to have ham salad on croissant. The ham salad was observed to have pickles mixed in it. The tray identification ticket indicated Resident #24 was to have no lunch meats or pickles.</p>		<p>suggestions. An "Also Available Favorites" menu is posted in the dining rooms for the alternative menu selections providing even more choices and staff were re in-serviced 8/7/2014. This alternative menu selection will be presented monthly to the residents in their Resident Council meeting. Meeting notes will reflect this. Randomly 2 residents will be interviewed concerning their satisfaction with their dietary preferences and personal clothing choices for the day, daily 5 of 7 days x 2 weeks, then weekly x 4 weeks. Observation and interview questionnaires will continue randomly weekly x 6 residents along with the Abaqis quarterly review, for the following 4 and 1/2 months. The observation and interview audit results and recommendations will be forwarded to the QA committee monthly x 6 months for further monitoring as indicated. Negative surveys/questionnaires or concerns could trigger for further monitoring. Six months of favorable surveys will result in determining the monitoring be stopped.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an interview on 7/17/14 at 12:30 p.m., Resident #24 indicated the ham salad contained pickles.</p> <p>The clinical record for Resident #24 was reviewed on 7/17/14 at 1:25 p.m. The clinical record indicated Resident #24 was on a controlled carbohydrate diet with no added salt.</p> <p>During an interview on 7/17/14 at 1:37 p.m., the Dietary Service Manager indicated the dietary staff should follow what the tray identification tickets indicate and she would be educating the staff regarding the identification tickets again.</p> <p>3. During an observation on 7/21/14 at 9:17 a.m., CNA (certified nursing assistant) # 3 was observed to assist Resident #47 to the room for personal care. CNA #3 assisted Resident #47 with choosing her clothes for the day. CNA #3 assisted Resident #47 with removal of her bed clothing and application of her clean clothes. Resident #47 indicated she did not like the neckline of the shirt she had chose. CNA #3 indicated it was the shirt the resident had chosen.</p> <p>During an observation on 7/21/14 at 9:43 a.m., Resident #47 was observed to be at the nurse's station indicating her hands</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were sticky and she did not like the shirt she was wearing. LPN #2 obtained a wet paper towel for Resident #47 to wipe her hands and indicated the resident's shirt was pretty. 3.1-3(u)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure ADLs (Activities of Daily Living) were provided in 1 of 3 residents, in that, a resident did not receive oral care or adequate personal care. (Resident #47)</p> <p>Findings include:</p> <p>During an observation on 7/21/14 at 9:17 a.m., CNA (certified nursing assistant) # 3 was observed to assist Resident #47 to the room for personal care. Resident #47 indicated she wanted to have her teeth brushed. CNA #3 assisted Resident #47 with choosing her clothes for the day and proceeded to assist the resident into the bathroom and onto the commode. CNA #3 assisted Resident #47 with removal of her bed clothing and application of her clean clothes. Resident #47 indicated she did not like the neckline of the shirt she had chose. CNA #3 indicated it was the shirt the resident had chosen. CNA #3 did pericare to Resident #47 and assisted the resident into the wheelchair.</p>	F000312	<p>It is the policy of Mt Vernon Nursing and Rehab Center to provide the necessary services to maintain good nutrition, grooming and personal and oral hygiene, for residents who are unable to carry out activities of daily living. All nursing staff will be re-in-serviced concerning procedures included in activities of daily living that are provided, with the emphasis on self direction and personal choice with a completion date of 8/8/2014. Two (2) residents will be identified randomly each shift for observation and interview on satisfaction of ADL care daily 5 of 7 days x 2 weeks, then weekly x 4 weeks. Weekly monitoring will continue through the Caring Partner program. This program offers each resident their personal advocate within the Team Leaders and is monitored for any issues of interest or concerns. This program is on-going. The observation audit results and Caring Partner documentation will be forwarded to the QA committee each month, for 6 months for further monitoring as indicated. Six months of favorable results will</p>	08/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER MOUNT VERNON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an observation on 7/21/14 at 9:43 a.m., Resident #47 was observed to be at the nurse's station indicating her hands were sticky and she did not like the shirt she was wearing.</p> <p>During an interview on 7/21/14 at 9:43 a.m., LPN #2 indicated if a resident did not receive a shower, the CNA should provide a partial bath to the resident. LPN #2 indicated the partial bath included washing the resident's face, hands, underarms, perianal, and any other areas that are needed. LPN #2 further indicated oral care should be provided during ADL care.</p> <p>The clinical record of Resident #47 was reviewed on 7/17/14 at 10:46 a.m. Resident #47 had a BIMS (Brief Interview for Mental Status) assessment score of 9 (nine) indicating moderate cognitive impairment. The clinical record indicated Resident #47 was an extensive assist of 1 (one) person for dressing and oral care.</p> <p>A care plan, dated 5/14/14, indicated Resident #47 was to be assisted, encouraged, or provided with a shower or bed bath with assist of 1.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(C)</p>		<p>result in determining the monitoring be stopped. Quarterly the Abaqis survey is completed which provides further opportunities for the resident to initiate or modify additional choices.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

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

F000441 SS=D	<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 -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</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</p>	F000441	It is the policy of Mt Vernon Nursing and Rehab Center to	08/18/2014
-----------------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER MOUNT VERNON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>interview, the facility failed to provide infection control procedures in 3 of 8 residents who received care, in that, hand hygiene was not performed and pericare was improperly given to a resident. (Resident #47, Resident #62, Resident #52)</p> <p>Findings include:</p> <p>1. During an observation on 7/21/14 at 9:17 a.m., CNA (certified nursing assistant) #3 was observed to assist Resident #47 with personal care. CNA #3 washed her hands for 5 seconds prior to applying gloves. CNA #3 assisted Resident #47 onto the commode, removed her bed clothes, and applied clean underwear, clothing, and shoes to Resident #47. CNA #3 assisted with standing Resident #47, obtained a wet wipe and wiped Resident #47's periaarea from back to front. CNA #3 discarded the wipe and obtained a fresh wipe and proceeded to wipe Resident #47's buttocks and rectal area. CNA #3 discarded the wipe and pulled up Resident #47 underwear and pants. CNA #3 removed the gloves and discarded them and assisted Resident #47 into the wheelchair.</p> <p>No hand hygiene was performed after ADLs (Activities of Daily Living) were</p>		<p>ensure an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. All nursing staff were re in-serviced 7/21/14 concerning the hand hygiene policy and procedure. All nursing staff will be re in-serviced on proper peri-care by 8/8/14. All licensed nursing staff will be re in-serviced on "clean wound dressing changes" by 8/8/14. One random staff will be observed for proper hand hygiene each shift daily x 1 week, then weekly x 4 weeks. Peri-care will be observed by the DON or designee daily 5 of 7 days x 1 week, then weekly x 4 weeks. The DON or designee will observe a licensed nurse perform a "clean wound dressing change" daily 5 of 7 days x 1 week, then weekly x 4 weeks. Monthly the infection control report will be submitted to the QA committee for review. Results will determine the need for further monitoring. Favorable results will determine the monitoring be halted. The observation audit results and recommendations will be forwarded to the QA committee for 6 months for further monitoring as indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>provided.</p> <p>During an interview on 7/21/14 at 9:27 a.m., CNA #3 indicated hands should be washed upon entering a room, when going from dirty to clean, and before exiting a room. CNA #3 indicated she did not really know how many seconds she should wash her hands. CNA #3 further indicated when doing pericare, you should wipe from front to back and she had done the front of the resident first and then proceeded to do the resident's buttocks and rectal area.</p> <p>2. During an observation on 7/16/14 at 1:22 p.m., LPN #2 was observed to change a gastrostomy tube dressing on Resident #52. LPN #2 washed her hands, donned gloves, opened a bottle of saline and 4 x 4 dressing. LPN #2 poured saline on a 4 x 4 and cleansed around the stoma and under the base of gastrostomy tube. LPN #2 opened a clean 4 x 4 and dried the area. RN #2 opened another 4 x 4 and placed it around gastrostomy tube. RN #2 removed her gloves and washed her hands. No hand hygiene or glove change was performed during the dressing change.</p> <p>During an interview on 7/21/2014 at 10:30 a.m., the ADoN (Assistant Director of Nursing) indicated handwashing and infection control</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000465	<p>education is done on a yearly basis and as needed when circumstances present.</p> <p>A policy, titled "Clean Wound Dressing Change," and obtained from the DoN (Director of Nursing) on 7/22/13 at 10:00 a.m., indicated hand hygiene and donning new gloves should be done after a dirty dressing is removed, cleaning of wound, and applying a new dressing.</p> <p>3. On 7/17/14 at 1:06 p.m., LPN #1 was observed to administer intravenous Vancomycin (a medication used to treat bacterial infections) to Resident #62. LPN #1 was observed to hand wash for 3 seconds following Resident #62's care.</p> <p>On 7/21/14 at 1:53 p.m., the DoN (Director of Nursing) provided the "Hand Hygiene - Plain Soap and Water Handwash" policy. The policy indicated, "A plain soap and water handwash or an alcohol hand rub may also be used: after removing gloves". The policy further indicated, "Rub hands together vigorously for 15-20 seconds....".</p> <p>This Federal Tag relates to Complaint Number IN00151928.</p> <p>3.1-18(b)(1) 3.1-18(l) 483.70(h)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

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

SS=E	<p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the environment was sanitary and comfortable for 9 of 31 resident rooms observed, in that walls were scuffed, corners and edges of floors were soiled, cove base was loose, walls were patched but not painted, and door panels were soiled. (Rooms #104, 154, 161, 112, 157, 135, 102, 159, 106)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Room 104 was observed on 7/16/14 at 9:48 a.m. There were scuff marks on the bathroom door and black marks on the door frame. The cove base behind bed 1 was coming loose from the wall. The bathroom floor was soiled with brown dirt in the corners. Room 104 was rechecked on 7/17/14 at 1:55 p.m. There were black marks on the door frame; the interior of the bathroom door was scuffed. The cove base behind bed 1 was laying in the floor. 2. Room 154 was observed on 7/16/14 at 1:15 p.m. The walls were chipped and dirt and debris was observed on the floor. The room was rechecked on 7/17/14 at 9:41 a.m. The trash can had no liner and 	F000465	<p>It is the policy of Mt Vernon Nursing and Rehab Center to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. A review of all resident rooms was completed on 7/22/2014 by Department Leaders. Repairs identified are in completion with a scheduled date of 8/20/2014. 5 bathrooms identified are being scheduled for floor replacement. Door kickplates have been ordered for replacements. The housekeeping staff and maintenance will continue with their departmental rounds weekly. All staff were re in-serviced on the room readiness checklists and using the housekeeping/maintenance work order system to assure that proper notification is timely on 8/8/2014. The Administrator will monitor the environment through daily/weekly rounds with the DON, Maintenance Director and the Housekeeping Director daily x 1 week, then weekly on-going. Monthly, a report is submitted to the contracted housekeeping services Area Director with identified concerns. Project requests are submitted to renovate areas as indicated by the residents, family and staff.</p>	08/20/2014
------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER MOUNT VERNON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the interior of the trash can was very soiled with brown dried smears.</p> <p>3. Room 161 was observed on 7/16/14 at 9:56 a.m. The bedroom and bathroom floors were soiled; there was a dead spider on the bathroom floor. The room was rechecked on 7/17/14 at 9:46 a.m. The room floor was soiled with dirt and debris. The bathroom floor had dried removable black soil to the right of the toilet.</p> <p>4. Room 112 was observed on 7/15/14 at 2:41 p.m. The wall behind the bed was patched, but not painted or sanded. The vinyl flooring in the bathroom was loose from the wall in the corner by the door. The room was rechecked on 7/17/14 at 2:18 p.m. and was the same.</p> <p>5. Room 157 was observed on 7/16/14 at 9:23 a.m. There was dried yellow soap drips down the wall between the sink and the toilet. The caulking around the sink was yellowed and cracked. The room was rechecked on 7/17/14 at 9:57 a.m. and remained the same.</p> <p>6. Room 135 was observed on 7/16/14 at 2:34 p.m. The faucet end had a hard crusty lime build-up around it; when the water was turned on, it sprayed out away from the faucet. The toilet bowl had the</p>		<p>The Caring Partners Program will also provide weekly communication and recommendations. All aforementioned requests and audits will be forwarded to the QA committee monthly x 6 months for further monitoring as indicated. Favorable reporting will determine any further monitoring. Quarterly, the Abaqis survey will provide additional reporting updates.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>finish worn off in the interior bowl. The room was rechecked on 7/17/14 at 1:42 p.m. The bathroom floor had a gray build-up throughout. The faucet continued to have a build-up and sprayed out away from the sink. The toilet bowl was the same.</p> <p>7. Room 102 was observed on 7/16/14 at 1:21 p.m. A metal corner piece of the wall was loose. The bathroom wall was marred. The floor around the commode was soiled/stained. The floor was soiled around the base of the bathtub rail. The room was again observed on 7/17/14 at 2:03 p.m. These items remained the same.</p> <p>8. Room 159 was observed on 7/16/14 at 9:27 a.m. The cove base was loose from the wall to the left of the bathroom door. The caulking around the bathroom sink was cracked. A bedside chair in the room had black soil/stains on the seat.</p> <p>9. Room 106 was observed on 7/16/14 at 10:08 a.m. The interior bathroom door had a plastic panel on the lower part of the door that had a build-up of soil; there were 3-4 bleached out drip lines on the panel. The door panel was observed to be the same on 7/17/14 at 2:10 p.m.</p> <p>10. On 7/22/14 at 11:00 a.m., the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER MOUNT VERNON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Director of Nurses was informed of the environmental concerns. She indicated there was a new head of housekeeping who was attempting to get things in better shape.</p> <p>This Federal Tag relates to Complaint Number IN00151928.</p> <p>3.1-19(f)</p>				