STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155118	A. BUILDING 00 B. WING	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	787 N DETROIT ST LAGRANGE, IN 46761

(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: 7/9-7/13/12 Facility number: 000049 Provider number: 155118 Aims number: 100270890 Survey Team: Carol Miller, RN, TC Honey Kuhn, RN Ann Armey RN Shelly Vice RN Debra Kammeyer RN Census Bed Type: SNF/NF: 75 SNF: 17 Total: 92 Census Payor Type: Medicare: 6 Medicaid: 60 Other: 26 Total: 92 These deficiencies reflect state	F0000	Miller's Merry Manor of LaGrange respectfully requests to dispute F-156, F 428 and F-441.Please accept this credible allegation of compliance to the findings of our annual survey beginning 7/9/2012.	

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

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 7/19/12 Cathy Emswiller RN			

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F0166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on observation, interview and record review the facility failed to address the request of a room rearrangement for 1 of 3 residents in a sample of 20 interviewable residents. (Resident #75) Finding includes: The record of Resident #75 was reviewed on 07/09/12 at 11:00 a.m. Resident #75 was admitted to the facility on 12/01/10 with diagnoses including, but not limited to, muscle weakness, hyperlipidemia, osteoarthritis, anxiety, depression, and legally blind. Resident #75 was interviewed on 07/10/12 at 10:50 a.m. Resident #75 indicated she had voiced concerns to staff in regards to her room arrangement. Resident #75 indicated following the admission of a roommate, during 06/2010, the room was rearranged to	F0166	F-166 Resident # 75's room furniture was rearranged to ensure the room mate's furniture does not extend into the "B" side of the room on 7/16/2012. All residents who have a room mate are at risk for this deficient practice. The SSD told the surveyor resident # 75 says she does not like sharing a room, not the "arrangement of the things in the room." The furniture was rearranged this spring per resident # 75's request. She was satisfied at that time and has not brought it up since then. Every semi-private room will be checked to determine the furniture is not extending into either side of the room unless both residents agree with the furniture arrangements. This will be completed by 8/9/2012. Five (5) semi-private rooms on each hall will be monitored by the SSD weekly x 4 weeks, then bi weekly x 1 month, then monthly x 6 months or until this is resolved. See QA tool titled, "Semi-Private Room Arrangement Review," see attachment # 4. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality	08/09/2012

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	accommodate the roommate. Resident #75 indicated, "They make this place smaller and smaller and are giving it to her." Resident #75 then continued on describing the changes which were made to the room. Resident #75 indicated she had repeatedly addressed the issue with various staff. Resident #75 indicated she had repeatedly been told, "We'll try it this way a few days" and "This is what works best for the room." The room of Resident #75 was observed throughout the survey: July 09, 2012 at 2:00 p.m. July 10, 2012 at 2:00 p.m. July 11, 2012 at 8:00 a.m. July 12, 2012 at 8:00 a.m. July 13, 2012 at 9:30 a.m. Resident #75"s area was on the "B" side/closest to the window. The room arrangement was observed to have the bed and overbed table from the "A" side extending beyond the curtain divider and into the "B" side. The record of Resident #75 was reviewed on 07/10/12 at 2:00 p.m. The Social Service Assessments were reviewed and indicated the repeated statement: "Resident understands her need for nursing care, but does complain quite frequently concerning the size of her room and the fact that she has roommate" on the following dates: 10/07/11 11/04/11 01/04/12 02/02/12 04/04/12 06/28/12 The SSD (Social Service Designee) was		Assurance meeting to monitor for ongoing compliance.	

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	interviewed on 07/12/12 at 1:10 p.m. The SSD indicated she meets with Resident #75 weekly. The SSD confirmed the resident does not like her room arrangement. The SSD indicated no interventions had been made. 3.1-7(a)(2)			

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F0223 SS=A	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review the facility to prevent mental abuse for 1 of 2 residents who met the criteria for abuse in a sample of 20 residents who were interviewed. (Resident #81) **Findings include:** **The Administrator was interviewed, on 07/12/12 at 11:30 a.m. in regards to abuse. The Administrator indicated the facility had initiated an investigation of an allegation of abuse reported by two CNA's (Certified Nursing Assistant) regarding the actions of another CNA, on 02/17/12 at 3:30 p.m., involving humiliation and intimidation of 2 residents. The Administrator indicated the facility immediately initiated their policy and procedure for abuse and suspended the CNA accused of intimidation. The CNA was**	F0223	It is the Policy of Miller's Merry Manor of LaGrange that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The facility must develop and implement written policies and procedure that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This is accomplished by completing a criminal back ground check and obtaining 2 reference checks on all potential employees. Professional nurses' licenses are verified through the Indiana Health Professions Bureau and all non licensed, potential employees are checked against the National Nurse Aide registry to ensure there are no findings against them. As part of their general orientation, all new employees are educated on abuse, recognizing abuse, who to report allegations of abuse to, how to protect residents from danger, and their responsibilities when witnessing what they	08/09/2012

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	terminated from employment from the facility on 02/18/12. **The Administrator provided, at the time, the Policy and Procedure titled, "Abuse Prohibition, Reporting and Investigation: Expires 07/11/12", which indicated:"** **"POLICY: 1. It is the policy of Miller's Health Systems that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.** **2. Miller's Health Systems has policies and procedures in place that prohibit mistreatment, neglect and abuser or residents...** **DEFINITIONS:...Mental Abuse-includes, but not limited to, humiliation, harassment, and threats of punishment or deprivation, isolating or involuntarily secluding a resident. Staff to Resident-any episode...."** **3.1-27(a)(l)**		believe to be abuse. In services are provided every 6 months to ensure continued education. It is the policy of Miller's Merry Manor of LaGrange to report al alleged mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility in accordance with State law through established procedures. Miller's Merry Manor of LaGrange must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while investigation is in progress. An investigation began immediately. The CNA who allegedly abused the 2 residents was suspended, pending the results of the investigation. The investigation determined the C NA was guilty of mental abuse and was terminated. The 2 residents involved were protected against further abuse during the investigation by the suspension and termination. Neither resident suffered physical injuries. Both of the residents have recovered from the mental abuse, although they remember it. This allegation of abuse was reported to ISDH immediately and the results of the investigation were reported to ISDH within 5 working days. The report included that the C NA involved was terminated as a result of the investigation. It is the responsibility of the	

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			Administrator, DON or their designee to report any allegation of abuse to the ISDH per facility policy and procedure.All residents are at risk for abuse. All staff was in serviced on “Abuse –Preventing, Recognizing and Reporting Resident Abuse” on 9/9/2011, 1/23/2012 and 7/18/2012. The facility will continue to provide in service training to all staff upon new hire and at a minimum of twice a year regarding the facilities policies for Abuse. The facility will continue to complete monthly Quality Assurance calls to resident families to also assist in monitoring the ongoing quality of care provided to our residents. The Quality Assurance tool titled ,” Resident Satisfaction Review” will be reviewed with residents during the monthly resident council meeting by social services or other designee. In addition, the “Resident Satisfaction Review” will be completed on 10% of the resident census on a monthly basis. See attachment # 20 a, b & c. The “Resident Abuse Audit Tool” will be conducted by the Administrator or her designee monthly for the next 6 months then every other month thereafter to ensure that the abuse policy and reporting are done per policy. See attachment #21. Any trends identified will result in immediate intervention/re-education and recorded on the Quality	

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			Assurance log to be reviewed during the monthly facility Quality Assurance meeting. It is the responsibility of the Administrator, DON or their designee to report any allegation of abuse to the ISDH per facility policy and Procedure.	

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F0246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. 1. Based on observation, interviews, and record review, the facility failed to address the request of a room rearrangement and ensure adequate reading light for 1 of 3 residents in a sample of 20 interviewable residents. (Resident #75) The facility failed to position 2 of 8 residents to enhance the dining experience (Resident #122, #67). **Finding includes:** 1. The record of Resident #75 was reviewed on 07/09/12 at 11:00 a.m. Resident #75 was admitted to the facility on 12/01/10 with diagnoses including, but not limited to, muscle weakness, hyperlipidemia, osteoarthritis,	F0246	F-246 See F 166 for Plan of Action to Resident # 75's request of a room arrangement. The reading light for resident # 75 was evaluated. The 40 watt bulb was replaced with a 100 watt bulb on 7/26/2012. Resident # 75 asked, "Was there something wrong with it?" All residents are at risk for this deficient practice. Maintenance will evaluate the lighting in all residents' room by 8/10/2012 to determine if it is adequate for their needs. The residents identified will be assessed for adequate lighting along with the quarterly assessments. This will be monitored by using the Quality Assurance "Activity Participation Review". See attachment # 5a and b weekly x 1 month, then quarterly with the assessments indefinitely to insure continued compliance. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance.Resident # 122 will be properly positioned so she can see and reach all her meal when	08/09/2012

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	anxiety, depression, and legally blind. Further review indicated the resident was legally blind in her left eye and had her right eye removed and replaced with a "glass" eye prior to admission. Resident #75 was interviewed on 07/10/12 at 10:50 a.m. Resident #75 indicated she is legally blind. The resident indicated she had need for more lighting to read by and had addressed the issue with facility staff and the issue had not been addressed. Resident #75 indicated she had voiced concerns to staff in regards to her room arrangement. Resident #75 indicated following the admission of a roommate, during 06/2010, the room was rearranged to accommodate the roommate. Resident #75 indicated, "They make this place smaller and smaller and are giving it to her." Resident #75 then continued to describe the changes which were made to the room. Resident #75 indicated she has repeatedly addressed the issue with various staff. Resident #75 indicated she has repeatedly been told, "We'll try it this way a few days" and "This is what works best for the room." The room of Resident #75 was observed throughout the survey.		she chooses to eat in her bed. On July 6, 2012 Resident # 67 was temporarily placed in the Broda Chair because she was causing pressure from rubbing her legs on the foot rest of the chair she was in before. She will either eat in a “geri-chair” in the main dining room or will be sat up in bed in a position where she can see and reach what is served. Resident # 67 was placed in a geri chair that sits up taller and gel leggings placed on her legs to prevent injury when she moves about. She is now seated at an over bed table in the dining room which can be lowered to the correct height. The care plan was updated to reflect this. All residents are who need assistance with positioning at meal time are at risk for this deficient practice. All residents requiring assistance with positioning during meals will be evaluated by 8/10/2012 by the DON or her designee. All staff will be in serviced on this on 8/7/2012. The DON or her designee will monitor positioning at mealtime 5 meals per week x 1 month, then 5 meals every 2 weeks x 1 month, then 2 meals per week x 3 months or until there are no residents identified as not being properly positioned 3 months in a row. See attachment # 6, "Proper Positioning at Mealtime."Any identified problems will be corrected and logged on facility	

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	July 09, 2012 at 2:00 p.m. July 10, 2012 at 2:00 p.m. July 11, 2012 at 8:00 a.m. July 12, 2012 at 8:00 a.m. July 13, 2012 at 9:30 a.m. Resident #75"s area was on the "B" side, closest to the window. The room arrangement was observed to have the bed and overbed table from the "A" side extending beyond the curtain divider and into the "B" side. The record of Resident #75 was reviewed on 07/10/12 at 2:00 p.m. The Social Service Assessments were reviewed and indicated the repeated statements in regard to Communication and Psycho/Social issues: "Resident understands her need for nursing care, but does complain quite frequently concerning the size of her room and the fact that she has roommate" on the following dates: 10/07/11 11/04/11 01/04/12 02/02/12 04/04/12 06/28/12 The SSD (Social Service Designee) was interviewed on 07/12/12 at 1:10 p.m. The SSD indicated she meets with Resident #75 weekly. The SSD confirmed the resident does not like her room arrangement and indicated no interventions had been made. The SSD was unaware the reading light was not adequate for Resident #75.		QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance.	

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	2. On 7/9/12 at 12:30 p.m. of Resident #122 was observed in her room sitting up in bed with the head of the bed at a 75 degrees angle. The resident's lunch tray was positioned above the resident's nose level. The resident was positioned so she could not see what the contents in the bowl were as she fed herself. 3. On 7/9/12 at 12:00 p.m., during observation of the noon meal in the main dining room, Resident #67 was observed sitting in a broda chair in the main dining room. The broda chair was very low to the ground and Resident #67 was positioned so her eyes were at the level of the table top with her arms below the table. The resident's food was on a plate on the table top and she was being assisted to eat by staff. The broda chair was positioned away from the table. The resident was not able to see her food and she was not sitting at the table with the other residents. . 7/12/12 8;00 a.m., Resident #67 was observed being assisted to eat her breakfast. The resident was sitting in the low broda chair. The resident's eyes were at the level of the table top. A staff person was spooning the food			

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	from the plate down to the resident's mouth, which was lower than the table. 7/13/12 at 8:20 a.m., the resident was again sitting in the low broda chair away from the table. The other three residents were sitting at the table. The clinical record of the Resident #67 was reviewed on 7/13/12 9:15 a.m. and indicated the resident was admitted to the facility, on 5/26/09, with diagnoses which included but were not limited to, Alzheimer's Disease, depressive disorder and anxiety. The Quarterly MDS (Minimum Data Set) Assessment, dated 5/8/12, indicated the resident had severe cognitive impairments and required extensive assistance for transfer and eating. The care plan for fall risks, had an intervention, dated 7/9/12, which indicated "Try broda chair for positioning to prevent falls and injuries." An Occupational Therapy evaluation, dated 7/11/12, indicated "confusion and agitation causing her to attempt to stand from w/c (wheel chair)." The			

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	therapy report indicated Resident #67 exhibited an upright posture when seated in the broda chair, "however, due to the height of the chair and no leg support, nursing feels like this is not the best option." The therapy outcome goal was to improve posture and skin integrity. There was no mention in the therapy report in regard to improving the resident's positioning in the dining room. 7/13/12 at 8:30 a.m. OTA (Occupational Therapy Assistant) #10 indicated Resident #67 had previously used a geri-chair but the nursing staff placed the resident in the broda chair this week because she was banging her leg when she tried to get out of the geri-chair. The OTA indicated nursing staff asked the therapy department to evaluate the broda chair. The OTA indicated the broda chair had no foot rests and the plan was to put her back in the geri-chair with gel protector for her legs. The OTA indicated the facility was awaiting the leg protectors so she could be placed back in the geri-chair. On 7/13/12 at 8:30 a.m., The OTA observed the resident sitting in the broda chair in the dining room and indicated Resident #67 was sitting too			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	787 N DETROIT ST LAGRANGE, IN 46761

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	low and should be put at a lower or smaller table. 7/13/12 at 9:26 a.m., Unit Manager #10 was interviewed and indicated there was no care plan for Resident #67 regarding positioning in the dining room but she was in the process of updating the resident's care plan to include concerns about positioning. The Nutrition and Hydration portion of the Nurse Aide Training Manual, dated 5/2006, provided by the Administrator, was reviewed on 7/13/12 at 1:30 p.m. and indicated, in part, "...position resident for comfort...Sit at eye level with the resident..." On 7/13/12 at 1:30 p.m., the Administrator indicated this was the only policy regarding positioning in the dining room that she was able to locate. 3.1-3(v)(1) 3.1-19 (k)(4)(D)			

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview,observation, and record review, the facility failed to provide activities in accordance to activities identified in Care Plans for 1 of 3 residents reviewed for activities in a sample of 8. (Resident #75) Findings include: The record of Resident #75 was reviewed on 07/09/12 at 11:00 a.m. Resident #75 was admitted to the facility on 12/01/10 with diagnoses including, but not limited to, muscle weakness, hyperlipidemia, osteoarthritis, anxiety, depression, and legally blind. Further review indicated the resident was legally blind in her left eye and had her right eye removed and replaced with a "glass" eye prior to admission. Resident #75 was interviewed	F0248	F-248 The 40 watt bulb was replaced with a 100 watt bulb in resident # 75's lamp on 7/26/2012. She asked, "Was there something wrong with it?" Resident # 75 scored between a 3 and 6 (severe impairment) on the BIMS. She was offered books on tape on 12/1/2010 but did not want to use them. She was offered books on tape again on 7/19/2012 and agreed to listen to them. That was the only day she listened. Staff has asked her daily if they can start the machine up. She has refused. She participated in the "Reading Club" on 4/3 & 5/23 and 5/31/2012 and was offered large print reading material on 5/23, 6/22 & 25/2012 and accepted them. She attended various other events throughout those 3 months. All residents who are unable to read and the assessment indicates they would like to read in some form are at risk for this deficient practice. The Activity Director will review all Activity Assessments and offer books on tape, large print items, invite to the reading club and current events by 8/20/2012. This will be monitored	08/09/2012

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	on 07/10/12 at 10:50 a.m. Resident #75 was queried if she receives assistance for things she likes to do, such as supplies and books. Resident #75 indicated, "No". Resident #75 indicated she is legally blind. The resident indicated she had need for more lighting to read by and had enjoyed listening to "books on tape" prior to her admission to the facility. The resident indicated she did not have access to large print materials and attended activities, at times, where they read current events. **Review of SS (Social Service) Notes, dated 06/28/12, indicated, "...The resident has moderate vision impairment..."** **Review of an Activities Assessment, dated 11/04/11, indicated: "How important is it to you to have books, newspapers, and magazines to read? Important, but can't do or no choice. How important is it to keep up with the news? Very important"**		by the Activity Director on 10 residents weekly x 1 month, then 10 residents monthly, ongoing, as part of our Quality Assurance Program. See Attachments 5a & b, “Activity Participation Review.” Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance.	

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	Review of Care Plans indicated: "Activities: 05/18/12: Goals...Resident will continue to participate in activities of interest on a regular basis. Interventions:...Resident states it is important for them (sic) to keep up with news. Activities will invite to all current events, and educational activities...." **"Visual impairment: (initiated 8/13/10 and updated 02/09/12) to right eye(s) related to: removal of right eye with glass eye prosthesis...Goals: Demonstrate compensatory way to deal with impaired vision. Interventions:...Use large print materials with resident (initiated 08/13/2010")** **Review of an "Intervention/Task" document for activity attendance, provided by the Activity Director on 07/12/12/ at 1:10 p.m., indicated Resident #75 had attended "Reading Club" a total of 5 times during April, May, and June 2012. Resident #75 declined Current Events 3 of 6 times the attendance record indicated the activity was offered for the same time frame.**			

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	The Activity Director (AD) was interviewed on 07/12/12 at 11:30 a.m. The AD indicated Resident #75 has not been offered any reading materials in large print. The AD further indicated several residents in the facility utilize books on tape format for reading needs. The AD indicated Resident #75 had not been offered books on tape. 3.1-33(a)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interviews, record reviews, and observations, the facility failed to ensure the safety of the 2 residents in regard to monitoring a resident during meals Resident #11) and during toileting (Resident #88). This deficiency affected 2 of 3 residents reviewed for accidents (Resident #88, #11) Findings include: 1. The record of Resident #88 was reviewed on 7/11/12 at 10:00 a.m., and indicated Resident #88's diagnoses included, but were not limited to, senile dementia, anxiety, and hypertension. Resident #88 was admitted to the facility 6/14/12. The Progress Note, dated 6/15/12 at 11:30 a.m., indicated Resident #88 had fallen off the toilet with the toilet riser observed on the ground apart under the resident. Interview with RN #36, on 7/11/12 at 10:15 a.m., in regard to the residents	F0323	F-323 Resident # 88 received no injuries from this fall. The "Ableware Tall-Elite Elevated Toilet Seat" was removed from the facility and discarded. A toilet safety frame was installed on the toilet. Resident # 88 did not want to use the new riser. It was removed. All residents with toilet seat risers have the potential to be affected by this deficient practice. All toilet seat risers that do not have legs were removed from the facility. Only toilet safety frames with legs will be used in our facility. All staff will be in serviced on 8/7/2012. This will be monitored by Maintenance using the Quality Assurance tool titled, "Maintenance Services Review" weekly x 1 month, then monthly x 3 months, then quarterly until the Maintenance Director is certain there are 0 toilet seat risers, without legs, inside our facility. No toilet seat risers without legs will be purchased in the future in this facility. See attachment # 6. When meals are served to Resident # 11, they will be completely set up, including unwrapping items. A heat and moisture barrier will be placed on	08/09/2012

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	fall and indicated the resident had fallen off the toilet and the toilet riser tipped over when the resident was leaning forward. RN #36 indicated the resident was an assist of 1 on the toilet but the resident was modest and did not want staff in the bathroom with her. RN #36 indicated a new CNA had not attach the toilet riser correctly to the toilet and the fall would not have occurred if the toilet riser had been correctly attached to the toilet. Interview with the Director Nursing Service (DNS) on 7/12/12 at 11:30 a.m. in regard to the fall and indicated the toilet riser was not attachable to the toilet and the resident leaned forward to wipe and fell off the toilet riser. The Investigation Report provided by DNS on 7/12/12 at 11:30 a.m. indicated as the resident leaned over the toilet riser slipped and flipped over off the toilet seat. Interview on 7/13/12 at 11:15 a.m. with the Certified Occupational Therapy Assistant #10 in regard to the residents fall and indicated therapy had not evaluated Resident #88 for the toilet seat riser. On 7/13/12 at 1:15 p.m. the undated		his lap before serving his food. A wireless camera was located where resident # 11 can be viewed in the lounge, facing the area where resident # 11 prefers to eat. The wireless monitor will be kept on a charger at the Central West Nurses Station. The camera will be turned "OFF" when Resident # 11 is not eating. The wireless monitor will be turned "ON" just before Resident # 11 is served his meal. An employee will observe resident # 11 while he eats by taking the wireless monitor with them, setting it on the desk or table where they are working/feeding, so they can observe and hear Resident # 11 eating. This is a small monitor so it cannot be viewed by several people at one time to insure privacy. When Resident # 11 finishes eating, the wireless monitor will be turned "OFF" and returned to the charger @ Central West Nurses Station. The policy and procedure titled "Observing Resident with Esophageal Stricture While Eating" was written. See attachment # 22. Residents with esophageal stricture and plan of care for increased risk for choking are at risk to be affected by this deficient practice. Any resident at risk will eat where they can be observed or will have a portable camera installed and be observed on a monitor. This will be monitored using QA tool titled, “Residents	

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	instructions were received and reviewed from the DNS for the "Ableware Tall-Elle Elevated Toilet Seats With Slip-In Lok- In-El Bracket... To install on Toilet:.. 2. Hold the Tall-Ette Elevated Toilet Seat so that the Lok-In-El bracket tongue points at a downward angle and slide the Lock-In-El bracket under the hinge pin between the bolts that hold the toilet seat in place. 3. As the tongue slides into place, the Tall-Ette Elevated Toilet Seat should come to rest directly on the china bowl with the bottom flange fitting inside the rim of the toilet bowl...." 2. On 7/11/12 between 1:47 p.m. and 2:05 p.m., Resident # 11 was observed eating in his recliner in the central lobby. The resident had pureed food on a plate in a metal warmer on his lap and was holding a glass of milk with a straw. During interview at that time the resident indicated he had trouble swallowing and swallowed "mighty slow." He indicated it took him quite awhile to eat and he had to go slow so eating in the main dining room "didn't work out too well." . A desert dish with a tan colored		identified as At Risk for choking" by the DON or her designee weekly x 4 weeks, then every other week x 1 month, then weekly x 3 months, then monthly until there are no residents with diagnosed esophageal srictures are living at Miller's Merry Manor of LaGrange.. See attachment # 6. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance.	

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	pudding, covered with plastic wrap and an item covered with foil were on a tray on the coffee table beside the recliner. The resident indicated he was not sure what was in the dish and indicated they wrapped it up so tight that he couldn't get the wrap off. The resident was observed to have trouble getting the foil off toasted bread that was wrapped in the foil but was able to free an end and take a bite of the bread. Two residents were sleeping in the lounge, at the time, but there were no staff present to assist and or monitor the resident while he ate his food. On 7/12/12 at 8:30 a.m., Resident #11 was observed in the Central lounge with a plate in his lap. The resident was eating pureed food. There were no staff present to assist and or monitor the resident while he ate his food. On 7/12/12 at 11:00 a.m., the Dietary Manager indicated the resident received a pureed diet because he had an esophageal stricture. On 7/13/12 at 8:30 a.m., Resident #11 was observed eating pureed food in the Central lounge. No staff were observed to be monitoring the resident.			

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On 7/13/12 at 9:30 a.m., the clinical record of resident #11 was reviewed and indicated the resident was admitted to the facility on 12/23/04, with diagnoses which included but were not limited to, depressive disorder, OCD (Obsessive Compulsive Disorder), dysphasia, esophagitis and stricture/stenosis of the esophagus.

The MDS (Minimum Data Set) Assessment, dated 5/10/12, indicated the resident had cognitive impairments and required extensive assistance for eating. The MDS did not identify choking or swallowing as problem areas.

Nursing notes, dated 5/18/12 at 9:10 p.m., indicated the "Resident c/o (complains) 'that (sic) knife in my throat that is choking me and making it hard to breathe.' Upon inspection, nothing visible in throat...."

The care plan for nutritional risk, revised 6/8/12, related to the esophagitis indicated "Monitor for S/S (Signs and Symptoms) of tolerance of texture and choking."

7/13/12 9:58 a.m. Unit Manager #12

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	indicated the resident started eating in the lounge around December 2011 and she had never observed any choking episodes since he had been eating in the lounge. The Unit Manager indicated he was not supervised during his meals but If he was choking we would do the Heimlich. The Unit Manager indicated she did not have a problem with him eating alone since he had never choked. The Policy for Dining room Assist Procedure, dated 1/3/2001, provided by the Administrator, was reviewed on 7/13/12 at 1:40 p.m. and indicated in part, "...7. Observe residents during meal..." 3.1-45(a)(1)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review the facility failed to assure 1 of 10 residents did not receive unnecessary drugs. In regard of the continued use of Vancomycin without consideration of symptoms and possible side effects. The facility also failed to assure toxic doses of Acetaminophen were not received. (#70) **Findings include:**	F0329	F-329 Resident # 70 chose to change physicians to physician # 11. Unit Manager # 12 contacted Physician # 11 on 7/13/2012 requesting evaluation of order for Vancomycin. It was discontinued the same day and order for re culture of stool in 2 weeks. This culture came back negative for C Diff. Isolation was DC'd. on 7/30/2012. All residents receiving antibiotics are at risk for this deficient practice. Each resident receiving antibiotics were assessed by the DON or her designee to assure they all had	08/09/2012

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	7-11-12 at 9:50 A.M., the clinical record of Resident #70 was reviewed and indicated the Resident's diagnoses included, but were not limited to, diabetes without complications Type II uncontrolled, Chronic Kidney Disease, Coronary Atherosclerosis, Polyneuropathy in Diabetes, Mononeuritis, Intestinal infections due to clostridium difficile (C-Diff) and retention of Urine. The Physician Order dated, 1-24-12, indicated Physician #9 reduced Vancocin 250 mg to three times a day with no end date. Review of physician orders indicated no new order in 2012 to re-culture Resident #70 or to discontinue the Vancocin. On 7-12-12 at 11:11 A.M., interview with Unit Manager #12 indicated that Resident #70 had an order for Vancocin for Clostridium Difficille (C-Diff). A copy of last C-Diff culture dated 6-3-10 indicated Resident #70 is positive for C-Diff. Unit Manager #12 states, Physician #9 "won't discontinue the Vancocin because he says she will always test positive for it". When asked about the physician change she stated, "Yes, she did change physicians, I hadn't thought to ask Physician #11 about that".		a stop date on 7/30/2012. All future antibiotic orders will be written with a stop date. All nurses will be in serviced on this procedure on 8/7/2012. All antibiotics ordered will be monitored using the Quality Assurance tool titled, “Infection Control Review” weekly x 4 weeks to ensure order contains stop date, then 5 antibiotic orders will be reviewed by the DON or her designee every other week x 4 weeks, then 5 antibiotic orders will be monitored monthly to ensure ongoing compliance. See attachment # 7a & b, titled, “Physician Order Review.” Resident # 70 received, at the most, 2,400 mg of Acetaminophen/day in the past 1 year. All orders for Acetaminophen and drugs containing acetaminophen will include: “not to excel 4,000mg/24 hours” All nurses will be in serviced on 8/7/2012. This will be monitored by the DON or her designee weekly x 4 weeks, then 5 acetaminophen orders will be reviewed every other week x 4 weeks, then 5 acetaminophen orders will be reviewed by the DON or her designee monthly to ensure ongoing compliance. See attachment # 7a & b, “Physician Order Review.” Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing	

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	The Progress notes on 7-12-12 at 11:10 A.M., indicated Resident #70 had chosen a new physician from Physician #9 to Physician #11 on 4/13/12. The Pharmaceuticals Consultant Monthly Summary was reviewed on 7-11-12 at 10:55 A.M. and was dated 12-5-11 thru 7-3-12, completed by Pharmacist #37 and indicated there was no recommendation to obtain a stop date for the Vancocin. 7-12-12 at 1:50 P.M. Review of Infection Control Policy titled Clostridium Difficile revealed in the Discontinuation of Precautions paragraph ,"may be discontinued when the patient is asymptomatic and as directed by the physician". Re-culture post treatment states, "Testing for Clostridium Difficile is not recommended if the patient's symptoms have resolved, as patients may remain colonized. Continue to observe the patient for 7-10 days after treatment for re-occurrence of active symptoms". Symptoms include but are not limited to watery diarrhea (more than three loose stools per day for two or more days, foul smelling stool, stool that is bloody, green or yellow-brown.		compliance.	

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	155118	A. BUILDING 00 B. WING	07/13/2012

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The CNA Bowel Movement Report titled BM Report indicated Resident #70 had no bowel movement on 6-15-12 and 7-8-12. Resident #70 had a medium bowel movement on 7-2-12.

On 7-13-12 at 8:20 A.M., the MAR indicated Resident #70 has a PRN (as needed) medication for diarrhea called Immodium. The order indicated to give Immodium 2 mg every 4 hours prn for loose stools. Resident received a dose on 6-15-12 and 7-2-12 on 7-8-12 the resident received two doses of Immodium.

Interview with LPN #34, 7-13-12 at 9:00 A.M., indicated she gave the PRN medication Immodium to Resident #70 for loose stools when she asks for it even though the BM Report indicated no bowel movements on those days. When asked if the she had consulted with the CNA's if Resident #70 had diarrhea or loose stool prior to giving the medication she indicated that she did not.

Mosby's Nursing Drug Reference 2011 p. 1160 provide by the facility indicated to use "Vancocin cautiously in renal impairment". Side Effects

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	included, but not were not limited to, nephrotoxicity, and fatal uremia. The Nursing Considerations were: Any patient with compromised renal system; "product is excreted slowly in poor renal system function; toxicity may occur rapidly". A laboratory report dated 5/3/12, indicated Resident #70's BUN (Blood Urea Nitrogen) was high at 21 and Creatine was high at 3.9. The review of the MAR on 7-13-12 @ 8:20 A.M., indicated Resident #70 is receiving multiple combinations of Acetaminophen which include Acetaminophen 325 mg two tablets twice a day, Vicodin/Acetaminophen 7.5/200 mg on Monday, Wednesday, and Friday. Acetaminophen 325 mg two tablets every 6 hours as needed for mild pain, Acetaminophen 325 mg tablets every 4 hours as needed for elevated temperature, and Hydrocodone/Acetaminophen 5/500 mg one tablet every 6 hours as needed for severe pain. The Pharmaceuticals Consultant Monthly Summary was reviewed on 7-11-12 at 10:55 A.M. and was dated 12-5-11 thru 7-3-12, completed by Pharmacist #37 and indicated there was no recommendation for			

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	parameters to be included on the MAR regarding maximum use of acetaminophen. Resident #70 had no parameters in the chart or on the MAR regarding daily maximum use of acetaminophen. Resident #70 could have over 4000 mg of acetaminophen a day when combining all combinations ordered. The Mosby's Nursing Drug Reference 2011 p. 84 was reviewed with DON on 7-13-12 at 9:15 A.M. and indicated daily doses greater than 4 Grams (1 gram = 1000 mg) from all sources may increase risk for liver toxicity. On 7-13-12 at 9:50 interview with LPN #34 indicated 3000 mg of Acetaminophen would be toxic for a Resident. Interview with LPN #30 at 9:55 A.M. indicates that 3000mg is now the toxic dose. She stated, "It use to be 4000mg" 3.1-48(a)(1) 3.1-48(a)(2)			

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F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on interview, record review, and observation the facility failed to include the total number of hours worked by nursing staff and the daily census in 4 of 5 days of survey. (July 10, 11, 12 and 13th, 2012)	F0356	F 356 The Daily Nurse Staffing is posted in the hall leading to the Southwest hall, a prominent place, readily accessible to residents and visitors. It is not accessed through a coded double door. Every day, visitors and	08/09/2012

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	Findings include: On 7/9/12 at 10:30 a.m. upon entrance to the facility an observation was made of the nursing staffing and daily census. It was located on the right side of the hall heading in to the Southwest hallway. The Southwest hall, the Central hall and the Northwest hall were all accessed through a coded double door between the front of the facility which include the Residential hallway, the Administration offices and the entry way into the locked unit of the Alzheimer's unit. A special code was required to access the Southwest hall way where the staffing was posted. It was noted that the 'census' was not written in on the nursing staffing. It was also noted that the total number of actual hours worked by nursing staff was also not provided on the forms. From 7/9/12 to 7/12/12 an observation was made on a daily basis at 9:00 a.m. and 3:00 p.m. and found to be missing the census and total daily hours worked of the nursing staffing. 7/12/12 at 11:20 a.m. the Director of Nursing Services (DNS) was inquired of the missing census and the missing total number of nursing hours worked. It was		employees enter these double doors between the front of the facility and the nursing facility by pushing the red button next to the door. A Daily Nurse Staffing has also been posted in the front lobby, next to the double doors and on the wall next to the entrance to the Dementia Care Unit. The nursing scheduler will post the Daily Nurse Staffing form each morning with the number of staff, both licensed and unlicensed, that are scheduled. A designated staff member will add the total hours at the end of each shift. This will be monitored daily by the DON or her designee daily x 7 days, then weekly x 4 weeks, then every other week x 4 weeks, then monthly on an ongoing basis to ensure continued compliance using the QA tool titled, “Daily Nurse Staffing” See attachment # 8. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance	

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	also noted that the location of the nursing staffing was located behind a coded access and isolated on one particular hallway versus being prominently displayed for all to see. It was noted by the DNS, "I usually don't put the census on the form until the next day..." It was also indicated that on the weekends, the responsibility of completing the census was delegated to central supply. It was noted by the DNS that she did not know the regulation for posting nursing staffing. 3.1-13(a)			

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F0372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure the lids, on 2 of 2 dumpsters observed, were closed. This deficient practice had the potential to affected 92 of 92 residents. Findings include: On 7/12/12 at 7:55 a.m., accompanied by the Dietary Manager, two dumpsters were observed outside the employee entrance, in the parking lot at the back of the building. The lids on the back of both dumpsters were open. The Dietary Manager indicated the dumpsters were so high the staff could not reach the lids so they kept them open. The Dietary Manager indicated she would talk to maintenance about getting smaller dumpsters. The policy for Garbage and Refuse, dated 2007, provided by the Dietary Manager, was reviewed on 7/12/12 at 12:45 p.m., and indicated "It is the policy that effective measures shall	F0372	F-372 The open dumpster was closed. This was left open by the trash collection company that morning. All residents are at risk to be affected by this deficient practice. Employees will not put trash in the dumpster through the top. A sign has been placed on the main dumpster stating, “Top lids must be closed at all times. If this one is full, use side door on recycling dumpster.” The trash collection company was asked to close the lids after they collect the trash. In the event the lids are opened, the person noticing it will use an implement to close the lid. All staff will be in serviced on 8/7/2012. This will be monitored by the CDM or her designee daily x 7 days, then twice weekly x 4 weeks, then weekly x 4 weeks, then monthly to ensure ongoing compliance using the QA tool titled, “Dumpster Lids Closed..” See attachment # 9. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance	08/09/2012

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	be utilized for protection against rodents, flies, cockroaches, and other insects.... 2. Dumpster area is clean and clutter free. The lid is kept shut...." 3.1-21(i)(5)			

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F0387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on interview and record review the facility failed to ensure Physician visit occurred at least every 60 days for 1 of 41 residents reviewed. (Resident #70) Findings include: Physician Progress notes, on 7-12-12 at 11:10 A.M., indicated Resident #70 had changed to a new physician from Physician #9 to Physician #11 on 4/13/12. Resident was to see her new Physician on 6-14-12 in his office. The review of office dictation dated 6-15-12 indicated that Resident #70 was assessed for a routine profile visit at the facility by the Family Nurse Practitioner (FNP). The physician #11 did not sign this dictation. Interview with Medical Records, LPN, on 7-11-12 at 2:55 P.M., indicated the medication rewrites dated 4/23/12 and 6-15-12, were signed by FNP.	F0387	F-387 Resident # 70 is scheduled to saw Physician # 11 on 7/31/2012. A letter was mailed to Physician # 70 reminding his office of the requirement when utilizing a physician extender, such as an FNP, the resident must be seen by the physician every other visit. See attachment 10 a, b, c & d. All residents whose physician utilizes the services of an FNP are at risk for this deficient practice. All residents whose physician utilizes an FNP were checked to determine the physician saw them every other visit. This will be monitored monthly by Medical Records utilizing QA tool titled, "Physician Services Review." See attachment 11a & b. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance.	08/09/2012

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	She confirmed the FPN works for Physician #11. The Physician #11 did not sign the rewrites. As a result there is no documentation the Resident was seen by the physician on either visit. 3.1-22(d)(4)			

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F0428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on interview and record review the facility failed to identify medications with possible negative outcomes for 1 of 10 residents reviewed for unnecessary medications (Resident #70) .Findings include: 7-11-12 at 9:50 am Record review of Resident #70 indicated diagnoses included but not limited to: Diabetes without complications Type ll uncontrolled, Chronic Kidney Disease, Coronary Atherosclerosis, Polyneuropathy in Diabetes, Mood Disorder, Mononeuritis, Edema, Intestinal infections due to clostridium difficile, Esophageal Reflux, Hyperlipidemia, Anemia Retention of Urine, Anxiety State, Senile Dementia and Cerebral Vascular Accident (Stroke). The Pharmaceuticals Consultant	F0428	F-428 Miller's Merry Manor of LaGrange respectfully requests to dispute this citation and request it be deleted. The facility is in compliance with this regulation as evidenced by the presence of documentation of Monthly Medication Regimen Reviews by the Consultant Pharmacist. This pharmacist was aware of Resident # 70's medication regimen and had been routinely monitoring her usage of acetaminophen on a monthly basis. Evidence found within the medical record reveals resident # 70 was administered 650 mg twice daily for routine total of 1,300 mg daily. Additionally, resident # 70 had as needed (prn) medications prescribed containing acetaminophen. Review of the medication records for the past twelve months reveal that Resident # 70 did not consume more than 1,000 mg of as needed acetaminophen in any 24 hour period. Her daily dosage of acetaminophen has been well below the 4,000 mg recommended daily dose.	08/09/2012

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	Monthly Summary was reviewed on 7-11-12 at 10:55 A.M. and was dated 12-5-11 thru 7-3-12, completed by Pharmacist #37 indicated there was no recommendation for parameters to be included on the MAR regarding maximum use of acetaminophen. Resident #70 had no parameters in the chart or on the MAR regarding daily maximum use of acetaminophen. Resident #70 could have over 4000 mg of acetaminophen a day when combining all combinations ordered. The Mosby's Nursing Drug Reference 2011 p. 84 was reviewed with DON at on 7-13-12 at 9:15 A.M. and indicated daily doses greater than 4 Grams(1 gram = 1000 mg) from all sources may increase risk for liver toxicity. On 7-13-12 at 9:50 A.M. interview with LPN #34 indicated 3000 mg of Acetaminophen would be toxic for a Resident. Interview with LPN #30 at 9:55 A.M. indicates that 3000 mg is now the toxic dose. She stated, "It use to be 4000 mg" 3.1-25(h)		Knowing this information, the consultant pharmacist would have no reason to generate a medication irregularity report and request administration parameters, as exceeding the recommended daily dosage of acetaminophen was highly improbable for resident # 70. See attached medication administration records and summary notes for July, 2011 through June, 2012. See attachments # 12a, b, c, d, e, f, g, h, I, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z, aa, bb, cc, dd, ee, ff, gg, hh, ii, jj, kk, ll, mm, nn, oo, pp, qq, rr, ss, tt & uu. LPN # 34 and LPN # 30 quoted 3,000 mg (3gm) as being the toxic level as that is the maximum daily dose of acetaminophen the Medical Director prescribes for his elderly patients. All orders for Acetaminophen will include "Not to exceed 4,000mg/24 hours". all nurses will be inserviced on 8/7/2012. All orders for Acetaminophen or drugs containing acetaminophen will be reviewed by the DON or her designee weekly x 4 weeks, then 5 acetaminophen orders will be reviewed by the DON or her designee every other week x 4 weeks, then 5 orders will be reviewed by the DON or her designee monthly to ensure ongoing compliance. See attachment # 7a & 7b, "Physician order Review." Any identified problems will be corrected and	

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			logged on the facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance. See F-329 for Plan of Correction.	

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F0441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, interviews and record reviews the facility failed to ensure	F0441	F-441 Miller's Merry Manor of LaGrange respectfully request to	08/09/2012

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	infection control practices were followed related to 3 of 3 resident investigated for infections and failed to implement the facility's infection control program to promote infection control. This deficiency potentially affected all residents in the facility, 92 of 92. (Resident #70, #94 and #102) The findings include: On 7/9/12 at 10:30 a.m. a tour of the facility was conducted. Isolation carts were observed outside of Resident #70, #94 and #102 in the hall Central West. Both rooms also had a sign on the resident's room door guiding visitors to report to the nurse before entering the room. Both of the rooms doors were open. Resident's #70 and #94's sign for guiding visitors to report to the nurse before entering the room was covered by a decorative straw hat. Resident #102 sign was not able to be read unless the decorative straw hat was moved. Resident #102 isolation cart had 4 drawers. Resident's #70 and #94's isolation cart had 3 large drawers. In comparing the physical appearance of the two rooms isolation carts, there appeared to be a difference. There was no identification of the type of isolation on either cart. An interview with RN #40 indicated both residents in Resident's #70		IDR F-tag 441 and request that the tag be deleted. The facility disputes citation of F-tag 441 with scope and severity of F for the following reasons. The 2567 indicates that based on observations, interviews, and record reviews the facility failed to ensure infection control practices were followed for 3 of 3 residents investigated for infections and failed to implement the facility's infection control program to promote infection control. It is imperative to note that 2 of 3 residents investigated were admitted with the infectious disease process and it was not a nosocomial infection. Miller's Merry Manor did not fail to communicate the need for isolation to the residents, staff or visitors as the resident room doors had signage in place indicating to STOP and see nurse before entering. The type of storage cart utilized for storing personal protective devices outside a resident room does not impact the care and infection control measures in place to care for each resident, nor does the facility infection control policy/procedures specifically define the type of cart that shall be utilized. All necessary supplies needed to care for the residents in isolation were available to staff in the carts per facility infection control policy and procedures. Dispatch disinfectant is utilized in rooms where a	

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	and #94 had Clostridium Difficile (C-Diff) and required contact isolation precautions. On 7/10/12 at 10:00 a.m. an observation was made of the isolation carts and notification signs on the front of the doors to Resident #70, #94 and #102's rooms on the central-west doors. On 7/11/12 at 10:00 a.m. an observation was made of the isolation carts and notification signs on the front of the doors Resident #70, #94 and #102's rooms central-west doors. On 7/12/12 at 10:00 a.m. an observation was made of the isolation carts and notification signs on the front of the doors Resident #70, #94 and #102's rooms central-west doors. On 7/13/12 at 10:00 a.m. an observation was made of the isolation carts and notification signs on the front of the doors Resident #70, #94 and #102's rooms central-west doors. Interviews were conducted concerning contact isolation precautions and the investigation and control of infections to prevent the onset and the spread of infections.		resident is in isolation for C-Diff. Dispatch disinfectant was readily available to the staff and routinely utilized to clean the isolation rooms of residents with C-Diff. The 2567 never indicates that improper disinfectant was observed being utilized. Staff repeatedly advised the surveyor of the need to use Dispatch in C-Diff rooms. The facility does not indicate what type of isolation is in place as this would be a violation to the rights and privacy of the resident whom is in isolation. The facility was following its facility policy by posting stop signs on resident doors with directions to see the nurse before entering the room. Each individual resident's plan of care includes specific regarding the type of isolation. Charge nurses are responsible to communicate to the facility staff what type of isolation precautions are in place and assist in oversight of the units to ensure proper techniques for the type of isolation are implemented/provided. Education to facility staff regarding the infection control policy and procedures, including C-Diff were provided on 2/22/12. See attached sign in sheets and in service content, # 13a, b, c, d, e, f, g, h & i. Numerous educational courses were provided by Silverchair in August, September, November and December of 2011 for all	

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	On 7/11/12 at 10:00 a.m. an interview was conducted with the Infection Control Manager, Assistant Director of Nursing (ADON) and the previous infection control manager, LPN #30. Upon interviewing both LPN's simultaneously, it was unclear to what the infection prevention and control program demonstrated. Neither LPN could completely discuss how the facility's surveillance, recognition, investigation and control of the infectious processes were controlled. LPN #1 indicated ongoing surveillance was monitored continuously through the "...24-hour report on the computer..." She indicated that all new orders, laboratory results, cultures on all residents were entered into this computer program by the floor nursing staff and ADON as the infection control nurse reviewed these every morning Monday through Friday at the beginning of her day. The recognition of the infections were made noted on a columned sheet titled, 'Infection Control Sheet' and done monthly. When inquired about this particular sheet of information in regard to trending, ADON and LPN #30 were confused and unable to accurately describe what the facility did with this information. The ADON was unable to discuss what, if anything, the facility was doing to investigate, control and prevent the further onset and spread		employees. See attached corse completion records # 14a, b, c, d, e, f, g, h, i & j, which provides evidence of ongoing staff education and training of facility staff regarding infection control policies and procedures. Efforts to provide this information to the surveyor were dismissed throughout the survey This is unfortunate as it is not proper survey protocol not to consider all the facts and evidence at the time of the survey. It is imperative to note that the interviews of staff throughout the 2567 are inaccurate and misleading as the content of the entire surveyor employee interviews are not accurately quoted. The process and technique utilized by the by the surveyor to gather information from staff through interviews lacked professionalism and the facility staff reported feeling intimidated and bullied. Staff were often unsure what information the surveyor was asking for and when queried by the staff for further explanation on what information was being requested the surveyor became more confrontational. Also lacking within the 2567 is the fact that the ADON had been in the Infection Control role for 1 WEEK and was still learning this role. Efforts were made by the ADON to share documents that show the monthly and quarterly Facility Infection Control Reports were in place to investigate, control and	

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	of infection within the facility. There was no indication of mapping of the current infections, or follow up to reoccurring infectious processes. When inquired about the investigative process of the infection control process it was noted that the primary care persons inform the nursing staff of certain criteria of possible infections. The nursing staff input this information into the computer system and notify the Physician and the Power Of Attorney. When inquired about the control of infections to prevent the onset and the spread of infections it was indicated that re-education is done by the Infection Control Nurse of the staff depending upon the specific infectious process. Inservicing was noted to be completed 1:1 or as a group with a return demonstration performance check off. When the Infection Control Nurse, ADON was conducted and inquired about the practices of reducing the spread of infection and controlling outbreaks through transmission-based precautions such as isolation precautions it was noted that an isolation cart was placed on the outside of the residents room and items that were dirtied in the room were disposed of and bagged in red isolation		prevent further onset and spread of infection within the facility. See Facility Control Monthly Report. Attachment # 15. What the surveyor conveyed to staff would be a 20 minute conversation about infection control resulted in a 2.5 hour session in which the new Infection Control Coordinator cried and the former Infection Control Coordinator was so upset and angry she could not think straight. The inability to express or communicate the facility's infection control program does not constitute a lack of an effective program or related processes and procedures. The use of adjectives such as "hesitant and lethargic" is opinions of the surveyor and not reflective of the evidence of compliance presented. The surveyor made no attempts to discuss the Infection Control program with the Director of Nurses and efforts by the ADON and DON to provide further clarity to the surveyor on facility surveillance and infection control monitoring program were dismissed by the surveyor through the survey process. Resident # 102 is no longer a resident at our facility. Resident # 70 had a stool culture that was negative for C-Diff on 7/30/2012. Isolation was discontinued for resident # 70. Resident # 94's C-Diff is colonized. Isolation is not necessary for her. All residents are at risk to be	

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	bags. When inquired about the facilities practice and processes concerning the consistency in preventing infections and preventing cross contamination both the ADON and LPN #30 referred to using the policy and procedures of the facility as a resource. When inquired and requested to see these, both LPN's referred to these being located on the computer and were both hesitant and lethargic with the ability to access them on their computer. When inquired about the use of records of incidents to improve its infection control processes and outcomes by taking corrective actions the LPN's referred to the computer system without examples. It was noted at this point that both LPN's were confused by the inquiring and indicated that neither one had been in the position as infection control nurse for very long. "... between (ADON's name) and I there was a nurse that did this job and didn't care for it..." was noted by LPN #30. The ADON made reference to "..quarterly reports completed by the lab..." It is the process of the lab servicing the facility to send a detailed report for review of the cultures of the infections, whom acquired the culture, when the culture was acquired		affected by this deficient practice. All staff will be in service for regarding facility policies and procedures for and Infection Control and Isolation Procedures will be presented on 8/7/2012. The corporate Quality Assurance Nurse will in serviced the ADON on the process for infection control surveillance, accessing infection control policies and procedures and isolation procedures. The ADON was trained by Miller's Merry Manor Infection Control Trainer 7/27/2012. Charge nurses initiate an infection assessment in the electronic medical record at the time of new onset of infection. This will be monitored by the DON or her designee utilizing the Quality Assurance tool titled, "Infection Control Review." This will be monitored 3x/week x 2 weeks, then weekly x 4 weeks, then monthly to monitor continued compliance. Any trends/findings will be logged on a QA log and reviewed in the facility's' Quality Assurance meeting. See attachment # 16a & b. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance.	

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	and what was being cultured. She indicated it was her responsibility as the infection control manager to review this information, input the information into the computer program of the facility, and to monitor antibiotics, antifungal's and consolidate a detailed report and make this information available to the units within the facility. This consolidated report showed why the infection was being transmitted and looked at the functional properties of the resident for problem solving into transmission possibilities and possible means of cross contamination. When requesting to see this type of report the ADON indicated she had done April and May of 2012 and on June 30th had gone over the entire month of June and reviewed all antibiotics that had been started, yet noted, "... I just haven't done the follow up..." No reports were provided for review. When inquired about the process and procedure to identify and prohibit employees with a communicable disease or infected skin lesion from direct contact with residents or their food both LPN's were lethargic with their responses. The ADON noted if a temperature were to be confirmed, the employees would be sent home. LPN #30 noted if an upper respiratory infection were suspected, the			

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	employees would be expected to wear a mask and change it every half-an-hour. When inquired about the facility's handling, storage, processing and transporting of linens as to prevent the spread of infections the ADON indicated the use of soiled linen barrels and noted, "...the red bagged linens are taken directly to the dirty side of the laundry, washed separately..." She also noted that the laundry staff are responsible for redistributing the barrels back to the dirty utility rooms the next morning. When inquired about the annual inservicing of the Infection Control Program to the facility, the ADON asked LPN#30 where the inservice records were located. LPN #30 provided guidance and accessed a record for 4/7/11. On 4/12/12, LPN #30 provided a sign in sheet with infection control highlighted in yellow under the title 'topic' yet no content was provided after inquiry times 3. It was unclear to 'what' was inserviced in under the topic of infection control. When inquired about Clostridium Difficile isolation precautions it was noted by LPN #30, "...I have no idea about that...I don't remember when that was done..." The ADON and LPN #30, Resident's #70, #94 and #102 of central west were			

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	discussed. It was indicated that Resident #102's isolation cart was there for unknown reason and that Resident's #70 and #94's isolation cart was there due to Bed A having active C-Diff and Bed B had a history of being C-diff positive and was "...just for precautions for her (bed B)..." On 7/12/12 at 9:30 a.m. an interview was conducted with the Housekeeping/ Laundry Supervisor in regards to contact isolation, processing of linens within a contact isolation room and the differences between the isolation carts located outside of Resident's #70, #94 and #102's rooms on the Central West hall. She noted that contact isolation was initiated by communication from the morning meetings at the facility. She noted it was the housekeeping's responsibility to clean the rooms with Dispatch with bleach and to keep a spray bottle of the Dispatch with bleach in the bottom drawer of the isolation carts located outside of the residents room whom have been placed on contact isolation. If other than contact isolation, the Dispatch disinfectant was not required. She did indicate there was a difference between the two isolation carts of Resident #70, #94 and #102 on the Central West hall. When inquired about Resident #102's isolation cart, it was indicated that Resident #102 was on			

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	isolation due to Methyl Resistant Staphylococcus Aurous (MRSA) not C-dif. She also indicated Resident #102 was a precautionary isolation only. When inquired about Resident #70 and #94's isolation cart, she pulled out all 3 drawers and made mention of the bottom drawer containing a bottle of Dispatch disinfectant due to her understanding that both resident #70 and #94 had C-Dif. When inquired about the processing of the linens in accordance to contact isolation precautions, she indicated that all trash and linens were bagged within the residents rooms, bagged in red biohazard bags and taken to the dirty utility rooms and placed in a barrel labeled biohazard. The linens were then to be transported by the laundry staff until the last shift of the laundry had gone home. At that time, the primary care staff were expected to transport the barrels in the dirty utility rooms to the hallway outside of the laundry room to await the morning shift of the laundry personnel to assume responsibility. On 7/13/12 at 9:10 a.m. an interview with CNA #31 was done about the isolation carts of Residents #70, #94 and #102 of the Central West halls. It was indicated that Resident #70 and #94 had C-diff; the cart held masks, gloves and gowns; it was also indicated that "...both			

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	residents were colonized now. When inquired again for accuracy of both residents having C-diff it was noted, ".. yes... C-diff..." It was also indicated that both carts held the exact same supplies and there was no mention of a special disinfectant for C-diff. On 7/13/12 at 9:30 a.m. an interview with Housekeeping/ Laundry Aide #32 was conducted. It was noted that when providing housekeeping/ laundry services for a contact isolation room the following items were conducted, "..gloves, bag trash in red bags, carry out to laundry... dispatch disinfectant is used for cleaning... it has a bleach thing in it...both rooms (Resident #70, #94 and #102) are cleaned with dispatch...because of that thing..." On 7/13/12 at 9:40 a.m. an interview with RN #33 in regards to the contact isolation precautions of Resident #70, #94 and #102. It was noted that Residents #70, #94 and #102 have, "..C-diff... to my knowledge they have been colonized..." In reference to the isolation carts outside of Resident's #70, #94 and #102 it was noted, "... no differences in carts and what is done (in regards to cleaning and preventing cross contamination)..." On 7/13/12 at 9:50 a.m. an interview with			

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	LPN #34 was conducted in regards to the contact isolation precautions of Residents #70, #94 and #102. It was noted when referencing Resident's #70 and #94 room, "...has C-diff... she's in isolation... she takes herself to the bathroom.... single bag biohazard red bags and then place in dirty utility..." "...Resident #70 is asymptomatic for C-diff and is on precautionary medication flagyl(antibiotic) prophylactic... the carts (Resident #70, #94 and #102's rooms) are the same... no differences... contain biohazard bags, gloves, gowns and face masks..." On 7/13/12 at 10:00 a.m. an interview with QMA #35 was conducted. She noted, "... I can't do anything with that form because as a QMA #35 I cannot do assessments... only the Unit Managers and nurses can do this form..." When inquired about contact isolation precautions she indicated that when contact isolation is initiated on a resident a sign is placed on the residents door to notify nurse before entering the room, a cart is placed out side the infected residents room that contains gloves, masks and gowns. When inquired about how dirty linen and trash are handled it was indicated the trash was single bagged and the linen double bagged in red biohazard bags while inside the infected resident room. Then the red bags were taken to the dirty utility room			

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	and placed within a white barrel with biohazard written on the top. It was indicated by the QMA #35 that the reason the trash was single bagged was because the white barrel served as the "..other bag..." On 7/13/12 at 10:15 a.m. RN #36 was interviewed in regards to the surveillance form and it's use. She noted, "...I haven't seen that form in the 6 years I've worked here..." When inquired about contact isolation she noted, "...the type of isolation depends on the symptoms and drainage... when symptoms are noticed, we culture the wound, red bag all bandages and place an isolation cart at the residents door...if it's nares drainage, the resident has to stay in their room... if no upper respiratory symptoms, they can go to the main dining room... removed from isolation after the antibiotic is done and wait for 2-3 days then reculture... we wait for a negative for MRSA (methyl resistant staphylococcus aurous) and if it's C-Dif (Clostridium Difficile) we go by colonizing... if MRSA by drainage..." On 7/13/12 at 10:35 a.m. LPN #30 Unit Manager of the North West Hall was interviewed in regards to the knowledge and use of the Infection Control Surveillance Report form. She indicated that this form was an "...old form... we			

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	don't use that anymore...the one we use now is located in the computer...it is filled out by the nurses; an LPN or RN; ... the ADON is really new...and I was still learning when I had that position..." A Nursing Infection Assessment was provided located with in the computer data system of PointClickCare. She noted that follow up was done daily until a medication was completed for a resident with an infection requiring an antibiotics. She noted if a problem was noticed, a call would be made to the Physician; the form was completed by answering specific questions along with the treatment ordered. At this point the Infection Control Nurse of the facility would review what infections are trending alongside of the labs..." On 7/13/12 at 11:00 a.m. the ADON was interviewed about the use of the surveillance form. She noted, "...I have never used that form in the 4 years I've worked here... Infection Control doesn't become involved in the tracking of an infection until an antibiotic is ordered... the night nurse relays the (symptoms) of an infection to the day nurse, the day nurse relays the information to the next shift... the day nurse follows up with the Physician being notified... On 7/13/12 at 11:00 a.m. the Director of			

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	Nursing Services was interviewed in regards to the tracking of infection control. It was indicated that the tracking occurred monthly. Record reviews were conducted between 7/9 and 7/13, 2012 as follows: Facilities Policy and Procedures for infection control: Clostridium Difficile (C-diff): " Treatment: Active Symptoms: 1. Initiate contact precautions... use an environmental protection agency (EPA) registered hypochlorite-based disinfectant solution when doing general cleaning in patient room and on all environmental surfaces within the room." Isolation Room Cleaning Specific to the C-Dif Organism: "1. Have designated cleaning equipment available for cleaning C-dif rooms. 2. This equipment includes pre-mixed dispatch hospital cleaner disinfectant with bleach prepared per manufacturer's instruction..." Policy: Education: A. Policy. 1. This facility provides ongoing education concerning infections and their prevention and management in the Long Term Care setting. B. Objectives: 1. The facility will educate staff on basic infection control			

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	practices upon orientation an at a minimum annually...4. All orientation and inservice education infection control techniques will be documented. This documentation shall be monitored by the Inservice Director...6. Inservice records shall be maintained...summary content of inservice..." Policy: General Policies of Infection Control Program: 5. D. Responsibility: 1. It shall be the responsibility of the Infection Control Practitioner through the infections control committee, to assure that all infection control policies and procedures are implemented and followed when necessary. E. Review of Infection Control Policies. 1. Our infection control policies and procedures... shall be reviewed at least annually...3. The Infection control Practitioner will track the use of topical, oral, intramuscular and intravenous antibiotics....4. Records shall be maintained of such reviews. Policy: Governing Implementation: ... B. Program Components: 1. Infection Control Practitioner is responsible for implementing, monitoring, and evaluating the Infection Control Program...10. Disease reporting records will be maintained of all infectious, contagious, or communicable disease found within this facility...Records shall be maintained			

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	and recorded on established forms approved by this facility...12. Personnel Guidelines: a. Personal with infections shall not be permitted to provide direct nursing care until a signed and dated physicians release certifying that the employee is free from any communicable disease is provided to the facility...13. In-servicing Training is required for all personnel at least annually. Periodically in-services are conducted to ensure staff members knowledge of current isolation and infection control practices. Policy: Infection Surveillance Program: A. Purpose: 1. To provide an accurate and complete data collection process relative to an infection...B. Procedure: 1. The Infection Control Surveillance Report Form is to be completed by the charge nurse when a resident is placed on an antibiotic...2. The completed form is to be maintained on the unit and reviewed by the Infection Control Coordinator at least weekly...7. The Infection Control Coordinator compiles the reports and logs them on the Infection Control worksheets monthly identifying any trends...8. If nosocomial (health care related infections) infections and trends are identified, plans of action to prevent further symptoms are initiated. Follow-up continues until the underlying reason for infection/symptoms is			

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	resolved. 9. The trends identified on the monthly Infection Control Worksheets are transferred to the Quarterly Infection Control Report to be reviewed at the Quality Assurance Committee meetings... C. Prevention, interventions and treatment of infections in the elderly population will be done by this facility:... 5. Education regarding hand-washing, standard precautions, isolation protocols, catheter care and peri-care will be provided at orientation, annually and as needed in response to infection control/ QI data. Policy: Reporting Procedure: 2. Reporting Procedure. A. Definition: Surveillance is the systematic scrutiny of all aspects of occurrences and spread of infection that are pertinent to infection control. B. Purpose. 1. To investigate, control and prevent infections. 2. To monitor effectiveness of policies and procedures for infection control. 3. To determine needs for the endemic rates of nosocomial (health care related). 4. To determine needs for investigation and/or corrective actions. 5. To identify possible sources (host, agent, environment) of infection. 6. To identify needs for staff, resident and visitor education. 7. To analyze cluster and/or significant increases in the rate of infections 8. To isolate the resident only to the degree needed to isolate the infecting organism. 9. To monitor the use			

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	of antibiotic medications. C. Monitoring Responsibility: 1. The infection control program will be monitored by the Infection Control Coordinator and Quality Assurance and Assessment Committee. D. Responsibility of the Infection Control Coordinator:...6. Weekly walking rounds to collect the concurrent, prospective infection data using reports from the nursing staff, chart reviews, progress notes, laboratory reports, medical records and clinical observations as well as environmental observations, physical assessments... E. Surveillance and Reporting Procedure: 2. A monthly nosocomial (health care related) infection report will be compiled by the Infection Control Coordinator... Policy: Transmission-based precautions room set-up: 3.C. Contact Transmission. 1. Supplies needed: gloves, gowns and designated linen and trash receptacles... An inservice dated 3/16/12 to all staff of the facility was conducted and was titled as follows: Biohazard Bag Policy, "red bagged LAUNDRY AND LINENS" The trash in the red bags will need to tied and placed in the biohazard container Immediately Located in the electrical room by the time clock. An inservice post test dated 4-7-2011			

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	labeled "instructions for the elderly' stated, " 9. What do you do with the isolation bags before you leave the room? Answer: tie them up and put them where they belong.(double bag)...put them in isolation barrels"; The Infection Control Sheet dated June 2012 included the following information: Infection (yes/no), Unit, Resident Name, Date, Type, Organism, Treatment. The 'Infection Control Surveillance Report' form provided the following information: 'any resident who has been in the facility longer than 72 hours if: there are signs and symptoms of infection *OR*, a culture is done *OR*, and antibiotic/antifungal is ordered *OR*, the resident is transferred to acute care or expires due to suspected infection. This form also included: residents name, record number, signs and symptoms with 43 choices of choosing, a place for the confirming the physician has diagnosed the infections and completed a visual assessment, the site of infection, any invasive devices, culture date obtained and source, x-rays obtained and type, antibiotic/ antifungal order date and medication, type of precautions implemented, signatures of nurse preparing report and signature of infection control coordinator.			

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A 'Facility Infection Control Monthly Report' sheet included: the facility, facility number, average census, date, actual census, and prepared by. The content of this form identified the number of infections and the source: wound/ skin, eye, urinary tract, respiratory, other(specify) and a total column for each. The topics included: A. Nosocomial-new, nosocomial-ongoing, non-nosocomial-new, non-nosocomial-ongoing and a total column for each. Also included on this monthly report form was the number of residents with catheters in the month. The infection rates by percentage were included and an optional prevalence rate area. The top of the form states, 'Miller Health Systems, Inc.'

On 7/12/12 at 10:00 a.m. a notebook lined paper was provided by the ADON with the handwritten title, 'Infection Control July'. 5 residents names were handwritten with a date, a location of infection and treatment. The ADON noted this was her infection control items for July 2012.

The Nursing-Infection Assessment of the PointClickCare computer system used for monitoring and recording the specifics of the infection process for the residents was reviewed. It included the residents name,

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	date, body systems affected, notification and treatment, IV assessment, respiratory system, genitourinary system, gastrointestinal system, eye/ear/ infection assessment, skin /wound infection, systemic infection assessment, bone infection, other site not included in the above. This assessment was completed by the nursing staff. A '24-hour summary' was provided by the ADON on 7/13/12 at 10:30 a.m. It included admissions, discharges, residents on leave, residents returning from leave, empty beds and a resident summary of all entries made by the nursing staff into the computerized data system in regards to the nursing- weekly assessments and the date of entry. 3.1-18(a)			

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F0469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observations, interviews and record reviews the facility failed to maintain a pest free environment. This deficiency affected 8 of 8 residents reviewed. (Residents #95, #1, #122, #121, #97, #106, #117, and #120). This deficient practice had the potential to affect 92 of 92 residents. Findings include: Observations were made from 7/9/12 to 7/13/12 as follows: 7/9/12 at 2:28 p.m. tiny black ants were noted on the bathroom floor of Resident #1's room. Activity Assistant #38 observed the ants and indicated it appeared as if the ants were after some food on the floor. 7/10/12 at 8:30 a.m. an observation was made in Resident #1 room. Dead ants were on floor. The area smelled of bug spray. 7/13/12 at 9:30 a.m. an observation was made in the physical therapy department of dead spiders and a beetle at the double doors leading to	F0469	F-469 The ants on the floor of resident # 1's room floor were cleaned and discarded. The dead insects in the therapy room were discarded. All residents are at risk to be affected by this deficient practice. The severe drought has caused insects, including ants, to enter buildings more than normal seeking moisture. The extermination records provided by the Maintenance Director were not only the monthly. The monthly reports were dated 4/10/2012, 5/7/2012 and 6/12/2012. The extermination record dated 6/25/2012 that was provided by the Maintenance Director was done when we identified that we had more insects inside the facility than normal. Arrow Pest Control was called to make an extra visit. The entire foundation, up to 3', eaves, soffits and overhangs were sprayed with Cy-Kick to minimize insects entering the facility from the outside of the facility. See attachments # 17a, b, c & d. Ortho Home Defense Max was sprinkled around the perimeter of the courtyards by maintenance. When insects are found the staff member who finds it will clean up any spills, etc, that may be	08/09/2012

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	the outside from the physical therapy department. An interview was conducted with the therapy staff and they indicated that there had been a problem with ants on and off at the double doors and that the facility had recently exterminated for ants around the entire perimeter of the facility. 6 Resident's were participating in the physical therapy department (Residents #122, #121, #97, #106, #117 and #120) 7/10/12 at 2:30 p.m. an interview with Resident #95's husband indicated he had visualized ants in her room before and had told the facility. He indicated that the ants, "..come and go..." On 7/12/12 at 10:00 a.m. an interview was conducted with the Maintenance manager and the Housekeeping/ Laundry Manager. The Maintenance manager indicated the facility had been recently exterminated for ants and that it has been a situation the facility has continued to manage. On 7/12/12 at 3:00 p.m. extermination records provided by the Maintenance manger was reviewed. Monthly exterminations were provided. 3.1-19(f)(4)		drawing them to that area, then complete a “Service Call” slip for Housekeeping and Maintenance. See attachment # 18. Housekeeping will clean the room/area. Maintenance will then use “Raze Flying & Crawling Insect Killer” that is for hospital use in the room, assuring there are no residents are in the area for at least 1 hour, per manufacturers directions. This will be monitored by the Housekeeping Director or her designee by using the Quality Assurance form titled, “Pest Control.” Eight rooms/areas will be monitored daily x 1 week, then twice weekly x 4 weeks, then weekly x 1 month, then monthly until no issues are identified 3 consecutive months. See attachment # 19. Any identified problems will be corrected and logged on facility QA tracking log and reviewed during the monthly facility Quality Assurance meeting to monitor for ongoing compliance.	

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