

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 21, 2014

Ms. Teresa Voci, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Ms. Voci:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 23, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2014
NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641	
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F 164	Continued From page 1 by: Based on observation, record review and staff interview the facility failed to ensure that Resident #91 was provided the right to personal privacy and confidentiality of his or her personal and clinical records. The findings include; 1. Per direct observation on 4/22/14 at approximately 8:30 AM, the state surveyor was standing in the hallway on Unit A, approximately 20 feet away from Resident #91 who was sitting in his/her wheelchair in front of the doorway of his/her room in the hallway. At the time of the observation there were approximately 3 other people in the hallway within close proximity to Resident #91. The facility Social Worker (SW) approached Resident #91 in the hallway and was observed asking Resident #91 questions related to feeling depressed, hopeless, trouble sleeping, feeling bad about yourself, and trouble concentrating. The Social Worker recorded the resident's responses on a piece of paper. Per interview with the facility Social Worker on 4/22/14, he/she confirmed in interview that he/she was asking Resident #91 questions in the hallway. The SW indicated when asked if he/she made it a habit to ask personnel questions to the residents in the hallway and he/she indicated "it depends on who is around and what is going on." The SW confirmed that the questions he/she were asking Resident #91 were eliciting responses of a personnel and confidential nature and that he/she was asking them in a public area. Per review of the medical record of Resident #91, the medical record indicated that on 4/22/14 at	F 164		

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F 164	Continued From page 2 8:44 AM the facility SW documented a section of the comprehensive assessment for Resident #91, indicating the resident's answers to the assessment questions that the SW asked Resident #91 in the hallway on 4/22/14 at 8:30 AM.	F 164			
F 241	483.15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to promote care for Resident #20 in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The findings include: Per direct observation on 4/22/14 at 8:22 AM, the medication nurse was outside the room of resident #20 preparing medications. The medication nurse knocked on the door that was partially open and the resident who was in the bathroom on the other side of the doorway yelled in response to the knock "Wait a minute". The medication nurse continued to attempt to push the door open which was hitting the open bathroom door and Resident #20 again yelled, "Wait a minute". The medication nurse continued to push the door open and entered the room, the resident yelled the roommate isn't even here, "I told you to wait a minute", the nurse replied	F 241	F241 483.15(a) 1. Resident # 20 had no negative effect as a result of the alleged deficient practice. 2. All residents have the potential to be effected by the alleged deficient practice. 3. Education provided to staff regarding dignity and respect. 4. Random observation audits at a minimum of weekly by the DNS or designee to monitor the effectiveness of the plan. 5. The DNS or designee will report the results of the audits to the QA committee for a minimum of 3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 5/23/14.		

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F 241	<p>Continued From page 3</p> <p>"Sorry Honey" and left the room.</p> <p>Per review of the medical record of Resident #20, in the comprehensive assessment, Resident #20 is alert and oriented and able to make his/her own decisions. The assessment indicated that Resident #20 was independent when tilting and independent in ambulation. The comprehensive care plan was reviewed and there was no evidence that the resident needed supervision/assistance when in the bathroom and could not be left alone in the bathroom.</p> <p>Per interview with the Registered Nurse who was the medication nurse, he/she confirmed that, he/she attempted to enter the room of Resident #20 to provide medications to the roommate. The nurse confirmed that after he/she knocked on the door that Resident #20 responded by saying "Wait a minute". The RN confirmed he/she had not explained the reason he/she was entering the room or acknowledge Resident #20's request to wait. The RN confirmed that he/she was aware that Resident #20 was in the bathroom with the door open and had asked a total of three times for the nurse to "wait" to enter and the nurse confirmed he/she continued to enter the room anyway.</p>	F 241	
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>	F 250	<p>F250 483.15(g)(1)</p> <ol style="list-style-type: none"> Resident # 120 now has a documented psychosocial evaluation in the medical record for the resident to resident altercation that occurred on 4/10/14.

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F 250	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide medically-related social services to services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 24 residents (Resident #120) Findings include the following: Resident #120 was admitted on 12/13/14 with diagnoses to include Senile Dementia with Delusional Features, Hypertension, Anxiety, Psychosis, Cognitive Impairment and Depression. Per medical record review on 4/23/14 at approximately 9:40 AM, a progress note dated 4/10/14 written at 14:59 by Licensed Practical Nurse (LPN), documents that the resident was involved in a resident to resident altercation. A Social Service note dated 4/10/14 by Social Worker (SW) identifies s/he attempted to meet with resident to assess mood. Resident was not in a space to speak, s/he was in pain, will follow up with resident tomorrow. Per medical record review on 4/23/14 at approximately 9:40 AM there is no evidence that the SW followed up with Resident #120 regarding incident dated 4/10/14. Per interview with SW on 4/23/14 at 9:40 AM, confirmation is made that s/he did complete a psychological assessment at the time of the incident dated 4/10/14, but the assessment can not be located in the electronic record or the medical record that was reviewed on 4/23/14. This was confirmed by both the SW and the Director of Nursing Services (DNS) on 4/23/14.	F 250	2. Any resident involved in an altercation has the potential to be effected by the alleged deficient practice. 3. Education provided to the social service department regarding the need for documented psychosocial assessment in the medical record following any resident to resident altercation. 4. Audits to be done by the DNS or designee for any residents involved in a resident to resident altercation to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 5/23/14.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	<p>Continued From page 5</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to ensure that comprehensive care plans were developed for 4 of 24 residents in the Stage 2 sample (Residents # 16,46,172,214). Findings include:</p> <p>1. Per record review on 4/22/14, the facility failed to develop a plan of care to address needs related to positioning of Resident #46's lower extremities. Resident # 46 there are diagnoses of Chronic Atrial Fibrillation with pacemaker placement; Reduced ejection fraction of 30% secondary to non -ischemic cardiomyopathy; Congested Heart</p>	F 279	<p>F279 483.20(d), 483.20(k)(1)</p> <ol style="list-style-type: none"> Residents #16, 46, 172, 214 care plans have been reviewed and revised. All residents have the potential to be effected by the alleged deficient practice. Initial audit completed to ensure residents care plans describe services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Education to staff regarding requirements for development, review and revision of care plans. Random weekly audits to be completed by the DNS or designee to monitor the effectiveness of the plan. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits. Corrective action will be completed by 5/23/14. 	

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F 279	<p>Continued From page 6</p> <p>Failure (CHF) and lower leg edema. H/she has a care plan related to CHF with potential for fluid overload/edema, but nothing that indicates to elevate his/her legs at all times per physician orders. Per observation at 11:20 AM Resident #46 was sitting in a chair in her room with her feet on the floor, this was confirmed by the LNA. At 2:35 PM after observation by this surveyor that resident was sitting in room in chair with feet on the floor and not elevated, the Physical Therapist in the room confirmed that the feet were on the floor and this was also confirmed at 2:38 PM by the Unit Manager. Per confirmation of Unit Manager on 4/22/14 at 2:38 PM, there was no care plan intervention regarding elevation of legs. Per interview with the LNA at 2:40 PM, the LNA did not know that the feet were to be elevated at all times. At 2:45 PM, the Unit Manager confirmed that the LNA assignment/care plan did not reflect that feet are to be elevated at all times.</p> <p>2. Per review of the medical record for Resident #16, there is no care plan to address urinary incontinence for Resident # 16. He/she was admitted to the facility with diagnosis that included end stage renal disease, difficulty walking and anxiety.</p> <p>Per review of the admission assessment dated 1/27/14 that indicated that Resident #16 was noted to be incontinent of stool, aware of bathroom needs, in need of assistance with toileting related to immobility and is never incontinent of urine.</p> <p>Per review of the 2/18/14, 2/25/14, and 3/17/14's comprehensive assessment, it indicates that Resident #16 is occasionally incontinent of urine.</p> <p>Per review of the medical record there are no nurses notes or physicians notes indicating any treatment plans, toileting schedules or</p>	F 279		

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F 279	<p>Continued From page 7</p> <p>Interventions related to assisting Resident #16 with his/her occasional urinary incontinent. Per review of the nurse aides documentation log, there was evidence that the aides had documented numerous episodes of urinary incontinence for Resident #16.</p> <p>Per review of the comprehensive care plan, there is no evidence that the care plan reflects Resident #16's urinary incontinent and a plan developed to reflect residents current status and interventions and goals to assist resident #16 regarding urinary incontinence.</p> <p>Per interview with the Registered Nurse on 4/22/14 at 230 PM, he/she confirmed that Resident #16 was occasionally incontinent of urine in the evening and after review of the comprehensive care plan, he/she confirmed that there was no care plan addressing Resident#16 urinary incontinent and no plan to assist Resident #16 with his/her incontinence and prevent further decline. The RN indicated he/she had no idea why Resident #16 was incontinent of urine.</p> <p>3. Per record review on 4/23/14 at 10:24 AM, there was no care plan to address the nutritional needs for Resident # 172. The Resident was admitted to the facility on 3/24/14. Diagnoses for Resident # 172 include Chronic pancreatitis; Advanced dementia; Depression; Diabetes; End stage renal disease; Hypercholesterolemia; Hyperkalemia and Hypertension. An assessment by a Registered Dietician (RD) dated 3/26/14 identified risks for dehydration due to use of a diuretic and pressure ulcers due to nutrition. Per interview with a facility RD on 4/23/14 at 11:01 AM, the RD confirmed there is no care plan for nutrition and stated that there should be one for this resident. The RD stated that the assessment was done by another dietician who should have</p>	F 279		

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F 279	Continued From page 8 created the care plan. 4. Per record review on 4/22/14, Resident # 214 was admitted on 4/09/14 with a history that included falls, difficulty walking, and cognitive deficits. The admission nursing assessment on 4/9/14 concluded that there was no indication for the use of side rails on the bed. After Physical Therapy completed the initial evaluation of the resident on 4/10/14, U shaped mobility side rails were recommended to assist in the resident being able to turn in bed. There was no mention of the use of mobility U bars on the Physical, Occupational, or Nursing plan of care. The bed was at the lowest position, with mats on either side, due to Resident #214 falling/rolling out of bed on 4/12/14. On 4/18/14, and 4/22/14, the resident had also rolled off onto the mat, however on 4/22/14 the resident's head was caught up on the Ubar so that the resident's body was on the mat with their head still on the bed. The U bars were removed from the bed immediately following the third incident, as staff realized that this was a safety risk for the resident. Per interview on 4/22/14 at 10:40 AM, the Physical Therapist stated that the therapists evaluate the resident and make recommendations to nursing for assistive devices, which nursing need to follow up on, and they initiate the care plan and any MD order needed for a particular device. The therapist confirmed at this time that the plan of care initiated by PT and OT did not include the use of the mobility bar, and that there was no specific assessment for safety in the medical record. Per interview on 4/22/14 at 12:15 PM, the Unit Manager confirmed that a plan of care was not developed to include the use of the U-bar mobility rails, and that the expectation was that it	F 279		

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F 279	Continued From page 9 would be included in Resident #214's plan of care as an assistive device.	F 279		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that services were provided that met professional standards of quality for 3 of 24 residents in the Stage 2 survey sample (Residents # 46, #138, #205). Findings include: 1. Per review of the medical record of Resident #138, the Nurses notes indicate that Resident #138 was admitted to the facility on 11/29/13 with diagnoses that included Pancreatic Cancer with metastasis. The notes indicated that Resident #138's health was declining and that the resident was placed on palliative care measures to ensure comfort for Resident #138 as his/her health continued to decline. Per the nurses notes dated 12/21/2013 at 05:31:05 am, the Licensed Practical Nurse (LPN) noted, tha the resident's son has been with him/her all night, resident given Ativan .25 ml and Morphine 2 mg at 200 AM per son's request, at around 415 am resident's respirations ceased, the physician was called an the on-call physician gave an order for the Registered Nurse to pronounce the resident's death. The Supervisor	F 281	F281 483.20(k)(3)(i) 1. Resident # 138 no longer resides at the facility. 2. Residents #46 and 205 had no negative effect as a result of the alleged deficient practice. 3. All residents have the potential to be effected by the alleged deficient practice. 4. Education provided to licensed Nursing staff regarding required documentation for resident death and RN pronouncement. 5. Education provided to licensed staff regarding Professional Standards as it relates to following physicians orders and medication administration documentation. 6. Random weekly audits to be completed by the DNS or designee to monitor effectiveness of the plan.	



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F 281	<p>Continued From page 10</p> <p>on call aware and stated to call one of the RN's who was coming in for 7-3 to see if one of them would come in early to pronounce.</p> <p>Per review of the nurses notes dated 12/21/13 at 6:23 am, written by the LPN the note indicated Registered Nurse (RN) Physician (MD) Pronounced at 6:10 am.</p> <p>Per review of the medical record there was no evidence that a RN or Physician assessed Resident #138 and pronounced the death at 6:10 am.</p> <p>Per review of the physician's orders, there was a telephone order dated 12/21/13, "Okay for RN to pronounce". The order was signed by the LPN.</p> <p>Per review of the nurses notes dated 12/21/13 3:21 PM by a Registered Nurse the note indicates funeral home took body at 10:20 am.</p> <p>Per review of the facility policy and procedure titled "Death of a Resident, Documentation" indicates, "A resident may be declared dead by a Licensed Physician or Registered Nurse with physician authorization in accordance with state law." The policy also indicates that "all information pertaining to a resident's death (i.e., date, time of death, the name and title of the individual pronouncing the resident dead, etc.) must be recorded in the nurses notes.</p> <p>Per interview with the facility Administrator on 4/23/14 at approximately 11:00 am, the facility Administrator reviewed the medical records of Resident #138 and confirmed that there was no documentation in the resident chart from an RN</p>	F 281	<p>7. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits.</p> <p>8. Corrective action will be completed by 5/23/14.</p>	

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F 281	Continued From page 11 for the pronouncement of death. The Administrator confirmed that an LPN can not pronounce a resident's death and confirmed that the physician order indicated an "RN to pronounce." Per interview the Administrator, confirmed that the expectation is the RN do the assessment and document in the medical record the assessment of death. 2. Resident #46 has diagnoses which include: Chronic Atrial Fibrillation with pacemaker placement; Reduced ejection fraction of 30% secondary to non-ischemic cardiomyopathy; Congested Heart Failure (CHF) and lower leg edema. Per review of his/her medical record on 4/23/14, the resident has an order from the physician dated 4/16/14 that indicates to keep legs elevated above his/her heart level. Per observation at 11:20 AM, Resident #46 was sitting in a chair in his/her room with feet not elevated and confirmation was made by the LNA that the resident was sitting in his/her chair and his/her feet were not elevated. Observation at 2:35 PM placed the resident in his/her room without feet being elevated and on 4/23/14 it was confirmed by the Physical Therapist that was in the room that Resident #46 feet were on the floor and this was also confirmed at 2:38 PM by the Unit Manager on 4/23/14. The Unit Manager also confirmed at this time that documentation in the treatment record of Resident #46 reflected the nurses had documented on 4/22/14 day shift that the resident had his/her lower extremities were elevated at all times, but that it did not appear as if this was being done. There was no care plan and the LNA care assignment did not reflect that feet were to be elevated.	F 281		
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F 281	Continued From page 12 3. Per record review on 4/22/14, Resident #205 was originally admitted to the facility on 3/19/14, after falling at home and generally declining. On 4/16/14, he was sent to the hospital for a period of unresponsiveness, and was admitted to the ICU with heart failure and pneumonia. He returned to the facility the following day 4/17/14 at 3:05 PM, with orders from the MD to provide palliative care. The resident complained of being in pain, and the nurse documented in a note that the resident received Ibuprofen 800 mg. The MD order reads " Motrin 800 mg. One orally every 8 hours as needed for moderate pain". There was no record of the time this was administered in the nurse's note, and review of the MAR revealed that the nurse had not put initials at the time of administration, and also had not written on the back of the MAR what time it was given, reason, or effect of treatment. Per interview on 4/23/14 at 9:15 AM, the Unit Manager confirmed that the nurse administering the Ibuprofen to Resident #206 had not signed off the medication on the MAR, or written out the information on the back of the MAR sheet, thus there was no way to know what time the medication had been administered to the resident, and that staff would not be able to determine when 8 hours had passed to be able to administer the next dose if needed.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 483.20(k)(3)(ii) 1. Resident # 148 Pressure Ulcer is resolved.	

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F 282	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to implement the care plan for 1 of 24 residents in the stage 2 sample (Resident # 148). Findings include: Per record review on 4/23/14 at 8:02 AM, staff failed to assess and/or document data regarding a pressure ulcer for Resident # 148. Per review of the pressure ulcer care plan, staff should monitor and document changes in skin status, appearance, color, wound healing, signs/symptoms of infection, wound size and stage. Per review of the treatment record (TAR) for March 2014 weekly skin checks are to be done every Friday by a nurse. Skin checks scheduled for 3/7, 3/14, 3/21 and 3/28/14. The 3/7/14 check is not documented. The rest are documented as done but with no indication whether skin is open or intact. Per interview and review of documentation with the Unit Manager (UM), h/she confirmed there was no documentation in the nursing notes or on the TAR indicating skin status as described above.	F 282	2. All residents have the potential to be effected by the alleged deficient practice. 3. Education provided to licensed staff regarding the requirement for documentation as it pertains to skin checks. 4. Random weekly audits to be completed by the DNS or designee to monitor the effectiveness of the plan with remedial measures implemented as needed. 5. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 5/23/14.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 483.25(d) 1. Resident #16 had no negative impact as a result of the alleged deficient practice. 2. All residents who are incontinent have potential to be effected by the alleged deficient practice.		

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F 315	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on the resident's comprehensive assessment, the facility must ensure that 1 of 3 resident's identified (Resident #16) who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. The findings include;</p> <p>Per review of the medical record for Resident #16, he/she was admitted to the facility with diagnosis that included end stage renal disease, difficulty walking, and anxiety.</p> <p>Per review of the admission assessment dated 1/27/14 that indicated that Resident #16 was noted to be incontinent of stool, aware of bathroom needs, in need of assistance with toileting related to immobility and is never incontinent of urine.</p> <p>Per review of the 2/18/14, 2/25/14, and 3/17/14's comprehensive assessment, it indicates that Resident #16 is occasionally incontinent of urine.</p> <p>Per review of the medical record there are no nurses notes or physicians notes indicating any treatment plans, toileting schedules or interventions related to assisting Resident #16 with his/her occasional urinary incontinence.</p> <p>Per review of the nurse aides documentation log, there was evidence that the aides had documented numerous episodes of urinary incontinence for Resident #16.</p>	F 315	<ol style="list-style-type: none"> 3. Initial audit completed to ensure those residents with identified incontinence have appropriate care plans. 4. Education provided to licensed nurses regarding the need for development of a care plan to address current continence status, interventions and goals. 5. Random weekly audits to be completed by the DNS or designee to monitor the effectiveness of the plan with remedial measures implemented as needed. 6. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits. 7. Corrective action will be completed by 5/23/14. 	

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F 315	Continued From page 15 Per review of the comprehensive care plan, there is no evidence that the care plan reflects Resident #16's urinary incontinence and a plan developed to reflect residents current status and interventions and goals to assist resident #16 regarding urinary incontinence. Per interview with the Registered Nurse on 4/22/14 at 230 PM, he/she confirmed that Resident #16 was occasionally incontinent of urine in the evening and after review of the comprehensive care plan, he/she confirmed that there was no care plan addressing Resident#16 urinary incontinence and no plan to assist Resident #16 with his/her incontinence and prevent further decline. The RN indicated he/she had no idea why Resident #16 was incontinent of urine .	F 315		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318

Continued From page 16

SS=D

IN RANGE OF MOTION

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and record review the facility failed to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 24 applicable residents, (Resident #111). The findings include the following:

Per medical record review on 4/22/14 at approximately 2 PM, Resident #111 was admitted on 1/22/09 with diagnosis to include Dementia, Psychosis, Delusional Disorder and Osteoarthritis. S/he is currently receiving end of life care.

Per interview with Licensed Nurse Aide (LNA) on 4/21/14 at 9:11 AM, confirmation was made that Resident #111 uses a splint when up. Since the splint was not on the resident's left hand, s/he was able to locate the device in the resident's bureau.

Resident #111 was observed by surveyor on 4/21/14 during Stage 1 observation without a splint on her/his left hand. Splint was applied

F 318

F318 483.25(e)(2)

1. Resident #111 had no negative impact as a result of the alleged deficient practice.
2. All residents requiring the use of a splint have the potential to be effected by the alleged deficient practice.
3. In-service education provided to licensed staff regarding the requirements for Splint use per the resident's plan of care.
4. Random weekly audits to be completed by the DNS or designee to monitor the effectiveness of the plan with remedial measures implemented as needed.
5. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits.
6. Corrective action will be completed by 5/23/14.

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F 318	Continued From page 17 when resident #111 was returned to bed after eating lunch on 4/21/14 at approximately 1:30 PM. Per interview with Unit Manger (UM) during Stage I, staff interview, on 4/21/14, s/he confirms that Resident #111 does not have any contractures. Per medical record review on 4/22/14 at approximately 2 PM, the Occupational Therapist (OT) evaluated the left hand of Resident #111 on 10/18/13 and found a mild contracture of the left hand. OT determined that therapy was necessary for splinting and neuro re-education. Without therapy patient is at risk for wounds and pain. Resident would benefit from a palm guard. Goals were met on 11/14/14 and therapy treatment discontinued. Plan was to continue with palm guard and care giver education was provided for frequency of use and how to donn this item. Recommends that palm guard be worn at all times except when the patient is being bathed or the splint requires laundering. Rehab manager confirmed the above information on 4/22/14 at 4:28 PM. Per LNA assignment for Resident #111, identifies that LNA staff are to apply left palm guard on all times except for care. LNA assignment documentation, provided by the UM who confirms on 4/22/14 that s/he was unaware that Resident #111 had a contracture.	F 318		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F332 483.25(m)(1) 1. Resident # 99 had no negative impact as a result of the alleged deficient practice.	

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F 332	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that it is free of medication errors of 5 % or greater. Findings include: 1. Per observation of a medication pass on 4/22/14 at 9:23 AM, staff administered 1 tablet of Docusate Sodium 100 milligrams (mg) by mouth to Resident # 99. At 9:30 AM on 4/22/14, the nurse that administered the medication confirmed that h/she administered 1 tablet of 100 mg Docusate sodium and confirmed that the physician's order was for Docusate/Senna 50/8.6 mg 1 tablet by mouth daily. 2. Per medical record review on 4/23/14 at approximately 8:30 AM, Resident #120 was admitted on 2/13/12 with diagnosis to include anxiety and senile dementia with delusions. Per physician orders for the month of April 2014, orders reflect that nursing staff is to administer Ativan 0.25 (milligrams) mg. by mouth (PO) three times a day (TID) as needed (PRN) for anxiety and Ativan 0.5 mg po at bed time PRN anxiety. Per Medication Administration Record (MAR) dated 4/10/14 at 1620 (4:20 PM), Resident #120 received Ativan 0.5 mg po for anxiety. Per interview with the Unit Manager (UM) on 4/23/14 at approximately 11 AM, s/he confirms that Resident #120 was provided her evening meal at 6 PM and was then assisted to bed at	F 332	2. All residents have the potential to be effected by the alleged deficient practice. 3. In-service education provided to licensed nurses regarding medication administration and documentation. 4. Medication administration competencies including observation were completed on licensed nursing staff. 5. Random weekly audits to be completed by the DNS or designee to monitor the effectiveness of the plan with remedial measures implemented as needed. 6. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits. 7. Corrective action will be completed by 5/23/14.		

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F 332	Continued From page 19 approximately 7:30 PM. Evidence demonstrates that bedtime was after 7:30 PM therefor Resident #120 should have received Ativan 0.25 mg PO for anxiety at 4:20 PM.	F 332		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that cooked food was maintained at proper temperature before serving. Findings include: Per observation on 4/21/14 at 12:16 PM during the noon meal, cooked food temperatures were checked from the steam table in the dining room and found to be below the recommended standard. The log with food temperatures taken before meal service showed the baked potatoes registering at 129 degrees F., and the Lima beans were recorded as being 150 degrees F. The pureed meat was recorded as being at 148 degrees F, and the gravy was recorded as reading 143 degrees F. According to the standards as listed on the temperature log, the baked potatoes and the Lima beans are supposed to be served at 160 degrees F, and the ground meat and pureed items are recommended to be at 170 degrees F. The server in the dining room confirmed the	F 364	F364 483.35(d)(1)-(2) 1. No residents were negatively impacted as a result of the alleged deficient practice. 2. All residents have the potential to be effected by the alleged deficient practice. 3. In-service education provided to all Food Services staff regarding maintenance of temperature logs, Food temperature ranges, proper documentation throughout meal service, corrective action for food temperatures out of appropriate range. 4. Random weekly audits to be completed by the Food Services Director or designee to monitor the effectiveness of the plan with remedial measures implemented as needed. 5. Results of the audits will be reported to the QA committee by the Food Services Director or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits.	

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F 364	Continued From page 20 temperatures that were written on the sheet, and stated that they thought the hot steam table would bring the temperatures up sufficiently. Per interview on 4/21/14 at 12:16, the Food Service Supervisor (FSS) confirmed that the temperatures were below the recommended safe food temperatures, and that the items should have been returned to the kitchen to be reheated up to the proper temperature before serving to residents. On 4/22/14 at 2:15 PM, the FSS stated that staff are trained to follow the guidelines as listed on the bottom of the temperature log, and are given instruction to reheat any items that do not meet this requirement.	F 364	6. Corrective action will be completed by 5/23/14.	