

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

June 4, 2012

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

Provider #: 475020

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 3, 2012**. 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, MS
Licensing Chief

PC:ne

Enclosure



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

MAY 29 2012

PRINTED: 05/16/2012
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 05/03/2012
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 000	INITIAL COMMENTS	F 000		
F 156 SS=D	<p>An unannounced on-site recertification survey was completed by the Division of Licensing and Protection from 4/30/12 to 5/3/12. The following are regulatory violations.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when charges are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the</p>	F 156	<p>F156</p> <ol style="list-style-type: none"> 1. Resident Rights were reviewed with Resident #192's responsible party 2. All residents have signed acknowledgment that Residents Rights were reviewed in writing and orally. 3. All new residents have the potential to be affected by this alleged deficient practice. 4. Re-education of the Admissions Coordinator regarding admission policy regarding resident rights will be completed. 5. Random weekly audits to be completed by Administrator or designee to measure effectiveness of plan 	

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

TITLE

(X6) DATE

Chloë Bueche

administrator

5/24/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and</p>	F 156	<p>6. The Administrator or designee to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time.</p> <p>7. Corrective action shall be complete by 5/28/12.</p> <p><i>F156 POC accepted 5/29/12 BHowe RN / Pincot RN</i></p>	

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F 156	<p>Continued From page 2</p> <p>procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that Resident Rights were explained for one (#192) of three sampled resident records reviewed. Findings include:</p> <p>Per review of the clinical record for Resident #192 on 05/02/12, no signed admission contract was noted. No evidence was documented in the record that the admission paper work, including a review of the Resident Rights, had been completed or attempted. Review of the facility policy titled Admission Agreement, undated, indicated that all residents shall have on file a</p>	F 156		
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F 156	<p>Continued From page 3</p> <p>signed and dated admission agreement. At the time of admission, the resident (or his/her representative) must sign an Admission Agreement that outlines the services covered by the basic per diem rate, as well as any additional services requested by the resident that are not covered by the basic per diem rate. The policy does not mention the review of resident rights. No facility policy was provided that specifically addressed the provision of resident rights in writing and orally as required.</p> <p>Per confidential family interview, conducted on 04/30/12, one residents' responsible party relayed that no admission paper work had been completed and no one from the facility had reviewed the Resident Rights with the Resident or the family. The family member stated that there was a folder in the drawer but stated there had not been time to review it. Interview of the Admission Director on 5/2/12 at 1:06 P.M. confirmed that the paperwork, including the resident rights, had not been reviewed with the resident or family since the admission on 04/16/12. The Admission Director stated the resident requested that the family be present and s/he had been unable to make contact with the family on daily rounds. When asked if a message was left with nursing to report the family's presence or if a phone call was made to family to make an appointment, s/he stated "no". The family member was observed in the facility on three occasions between 04/30/12 and 05/03/12. The Licensed Social Worker was interviewed on 5/3/12 at 11:30 A.M. and denied that s/he spoke to the Resident or family about resident rights or admission paper work during meetings related to care. S/he stated s/he was unaware that the</p>	F 156			

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F 156	Continued From page 4	F 156		
F 253 SS=E	<p>admission process had not been completed.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and confirmed through staff interview the facility failed to maintain a sanitary homelike environment for all residents. Findings include:</p> <p>Throughout the days of survey, the following observations were made:</p> <p>a. In the bathroom of room B-10 there was an open space approximately 6 inches wide between two ceiling tiles above the sink and toilet, from which dust and debris had fallen onto the floor;</p> <p>b. In the bathroom of room B-17 the ceiling light was without a cover exposing metal and bare bulbs;</p> <p>c. In the bathroom of room B-22 the sprinkler head was hanging below the tile from which it had been placed leaving a large hole around the hardware and from which dust and debris hung.</p> <p>d. In room A-12 the the front cover of the heating element, located along the floor beneath the window, was pulled away, hanging and exposing the inner fixtures and sharp metal edges.</p>	F 253	<p>F253</p> <ol style="list-style-type: none"> Items identified A-F were addressed and resolved at time of survey 5/3/12. All A and B wing resident rooms and care areas are at risk of this alleged deficient practice. Staff will be re-educated regarding the process of communicating environmental areas that need to be fixed. Random weekly audits to be completed by Administrator or Designee to measure effectiveness of plan start by 5/28/12. The Admin or Designee to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 	

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F 253	Continued From page 5 e. The baseboard along the bottom of the wall in the bathroom of room A-17 was loose and bulging away from the wall. f. The whirlpool tubs on both A and B Wings had lime scale build up around the faucet and handles and there were rusty colored stains on the interior of both tubs leading from the faucet area down to the tub bottoms. In addition, the tub on A Wing was dripping water continuously from the faucet throughout the first day of survey and was repaired only after the surveyor notified the Nurse Manager of the issue. The above observations were confirmed by the Director of Maintenance during environmental tour of the facility on the afternoon of 5/2/12.	F 253	6. Corrective action shall be complete by 5/28/12. <i>F253 POC accepted 5/29/12 BHOWERN/AMCOTARN</i>	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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	F 279	F279 1. Resident #5 has a care plan in place for pressure ulcer prevention. Resident #43 has an updated care plan that reflects the type and location of vascular access device used for HD. A diet manual will be made available for staff to reference specific therapeutic diet information.	

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F 279	<p>Continued From page 6</p> <p>§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 record review and staff interviews, the facility failed to develop care plans based on comprehensive assessments for two residents in a Stage 2 sample of 20 residents. (Residents #5 & Resident #43). Findings include:</p> <p>1). Per record review and staff interview the facility failed to develop a Care Plan for a resident (Resident #5) with a history of pressure ulcers, for pressure ulcer prevention. The Resident had two unstageable Pressure Ulcers due to deep tissue injury noted in the Significant Change MDS dated 09/19/2011. The quarterly MDS dated 12/12/11 shows no pressure ulcers present. The quarterly assessment dated 09/06/2011 states that there are no pressure ulcers at Stage I or greater. A progress Skin/Wound note dated 10/25/11 states that pressure areas on the resident were assessed to include:</p> <p>a. Left Heel unstageable b. Left Coccyx Stage III c. Center Coccyx Stage III presenting as a Stage II d. A resolved area below the right buttock.</p> <p>In this resident's record no other MDS from 03/9/11 to 3/12/12 codes any pressure ulcers present. The Braden Scale assessments present in the record all rate the resident between 15 and 18 at risk for pressure ulcer development. There is a discontinued Care Plan for Actual Impaired Skin Integrity r/t Pressure Ulcers for the</p>	F 279	<p>2. Any resident at risk for pressure ulcers or those that receive dialysis services or on therapeutic diets are at potential to be affected by this alleged deficient practice.</p> <p>3. The care plans of all current residents that receive HD services will be updated to reflect type and location of the VAD device. All current residents at risk for pressure ulcers will have prevention care plan in place. Diet manuals will be placed on units and dining room to serve as a reference for those with an order for a therapeutic diet.</p> <p>4. Staff will be educated on location and use of diet manuals and re-educated for the following: care planning for HD</p>	

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F 279	<p>Continued From page 7</p> <p>above noted pressure areas. There is, in addition, a deep wound on the resident's lower lumbar spine, which is believed to have begun as an abrasion on the residents back. The resident has a Care Plan for Actual Impaired Skin Integrity r/t Deep Tissue Injury with Surgical Debridement (not identified as a pressure ulcer) now present. The care plan does include a pressure relieving mattress and a gel pad for the bedside commode, but does not address goals or interventions specific to pressure related skin impairments or the potential for.</p> <p>There is no Care Plan for Risk for Impaired Skin Integrity or Pressure Ulcer Risk in the record. In an interview on 05/02/12 at 3:10 PM the Unit Manager acknowledged that s/he had not developed a care plan for Pressure Ulcer Risk and/or Pressure Ulcer prevention for this resident.</p> <p>2. Per review, Resident #43, whose medical conditions included ESRD (End Stage Renal Disease) for which s/he received Dialysis, had a comprehensive care plan that did not include the type of information that would assist staff in knowing what foods would be appropriate for the resident's consumption. The resident's Admission MDS (Minimum Data Set) Assessment, dated 10/17/11, identified that the resident's therapeutic diet may affect intake by limiting food options and/or altering the appeal of food, and the Nutritional Assessment, dated 4/6/12, identified</p>	F 279	<p>residents; care planning for pressure ulcer prevention.</p> <ol style="list-style-type: none"> 5. Random weekly audits to be completed by DNS or designee to measure effectiveness of plan 6. The DNS or designee to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 7. Corrective action shall be complete by 5/28/12. <p><i>F279 POC accepted 5/29/12 BHowe RN / Pincot RN</i></p>	

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F 279	Continued From page 8 the diet order as Liberal Renal. A Nutrition Report Card, provided to the resident and staff by the Dialysis Unit, for February, 2012, identified the resident's phosphorous level at 5.50 with an acceptable range of 3.5 - 5.5. Although the Report Card indicated the importance of following a low phosphorous diet to prevent high blood levels of phosphorous and identified foods that should be avoided, this information was not included in the resident's care plan. The care plan stated; "diet as ordered...monitor meals...Supplements as ordered...Honor preferences as able, offer alternatives prn (as needed)". In addition, the care plan did not identify the type or location of vascular access device used for HD (Hemodialysis) treatments. During interview, at 8:30 AM on 5/3/12, both the Nurse Unit Manager and the RD (Registered Dietician) confirmed the lack of specific diet information on the resident's care plan. During separate interviews with LNA #1 and LNA (Licensed Nursing Assistant) #2, on 5/3/12 at 11:51 PM and 12:10 PM, respectively, neither of the LNAs were able to identify more than one specific food item that should be avoided by the resident and both stated they would utilize the care plan for the information. Both also identified that the meal ticket would include foods to be avoided. Per review, at the time of interview, both LNAs confirmed that the Resident's current noon meal ticket did not include any food items to be avoided.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	F280 1. Resident #174 care plan was revised to note significant	

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F 280	<p>Continued From page 9</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that the care plans were revised to reflect interventions for care for two of 20 applicable residents. (Residents #75 and #174) . Findings include:</p> <p>1). Per record review and staff interview, the facility failed to update the Nutritional care Plan for Resident # 174, who had significant weight loss, to include the initiation of Mighty Shakes on meal trays, the continued weight loss, and dietary preferences and foods/snacks provided by the family. The resident's weight on 01/27/12 was 130 pounds and on May 2, 2012 was 115.2 with the lowest weight recorded 04/30/2012 of 114.8 (a reweigh on May 2 showed a weight of 115.2</p>	F 280	<p>weight loss and updated interventions. Resident #75 currently out of facility.</p> <ol style="list-style-type: none"> 2. All residents are at potential to be affected by the alleged deficient practice. 3. Dietician and Activity Staff will be reeducated regarding process for updating care plans. 4. All current residents food preferences will be communicated to staff and education provided to staff on location of information. All activity care plans will be updated, participation in activities of interest by residents will be monitored. 		

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F 280	<p>Continued From page 10 after an initial weight of 113.2). The first significant weight loss noted was a loss of 5.9% (7.5#) over 30 days noted on 03/14/12. As of 05/02/12 the resident experienced a 10.7% weight loss over 90 days and an 11.7% weight loss over 180 days. The care plan did note a weight loss which was added to the focus section of the care plan on 04/15/12.</p> <p>Per interview with the RD on 05/03/12 at 11:45 AM the care plan does not reflect the weight loss note of 04/09/12 in which the resident's spouse stated that the resident liked ice cream in the afternoon and stated that s/he would give him/her ice cream in the afternoon. The note also states that the family provides snacks, treats, and Ensure which is not reflected in the care plan. On 04/30/2012 the resident's family requested that staff offer ice cream to the resident when family is not present which was not updated in the care plan. In interview the RD stated that the information, though not in the care plan was in the notes but that s/he had not added those specifics to the care plan. In the interview on 05/03/12 at 11:45 AM the Unit Manager stated that s/he had not updated the care plan with the information.</p> <p>2. Per medical record review on 05/02/2012 at 1:30 PM, the initial activity assessment was done 05/2011 and included a care plan that indicated that an update was needed in Feb 2012. There is no updated activity care plan in the medical record, either in the hard copy or the electronic record and this is confirmed by the Activity</p>	F 280	<ol style="list-style-type: none"> 5. New information regarding food preferences for any resident will be communicated to staff utilizing a care plan acknowledgement sheet and LNA lists and education will be provided to staff on this new process. 6. Random weekly audits to be completed by Administrator or designee to measure effectiveness of plan. 7. The DNS/Administrator or designee to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 8. Corrective action shall be complete by 5/28/12. <p><i>F280 POC accepted 5/29/12 BHowe RN / QMeatRN</i></p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 05/03/2012
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F 280	Continued From page 11 Director during interview on 05/02/2012 at 2:30 PM. S/he further indicates that this resident prefers to be in his/her room, watching the TV. S/he states that s/he and the activity staff visit this resident at least 2 times per week to offer different approaches, even offering books on tape. There is no evidence to indicate that this has happened. There is no evidence to support that this has happened or is part of Resident # 75's care plan.	F 280			
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. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview, the facility failed to assure monitoring occurred, in accordance with the plan of care, for one resident (Resident #43). Findings include: Per review, there was no evidence of ongoing monitoring of the HD (Hemodialysis) access site for Resident #43, in accordance with the resident's plan of care. The most recent care plan, dated 4/6/12, identified that the resident received outside services for dialysis 3 days a week and directed staff to, "monitor venous access device for signs and symptoms of infection.". The facility's Policy and Procedure, titled; Hemodialysis: Pre and Post Care, last revised on 7/19/02, stated, under Daily Nursing	F 282	1. Resident #43 care plan was updated to reflect location and type of vascular access device for HD. Per the policy titled Hemodialysis: pre and post care, monitoring of the VAD site has been added to the TAR. 2. All residents care plans and TAR's for those receiving HD have been updated. 3. All residents receiving HD have potential to be affected by this alleged deficient practice.		

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F 282	Continued From page 12 Care of Resident on Hemodialysis; 1. Monitor vascular access site every shift and document on TAR (Treatment Administration Record). Per review of the resident's record there was no evidence that staff had monitored the HD access site. In addition, the care plan did not identify the type or location of vascular access device. During interview, at 8:30 AM on 5/3/12, the Nurse Unit Manager confirmed there was no evidence that the resident's access site had been monitored.	F 282	4. Nurses will be reeducated regarding the policy for residents receiving HD.	
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through staff interview the facility failed to assure hand rails for resident use were maintained in a manner to prevent accidents. Findings include: Per observation during initial tour of the facility, on the morning of 4/30/12, some of the handrails attached along the corridor walls on all wings, and utilized by residents, were noted to have multiple areas where the wood was rough and gouged with jagged edges creating the potential for splinters and accidental injury. During the initial tour, a splinter was embedded in the forearm of	F 323	5. Random weekly audits to be completed by DNS or designee to measure effectiveness of the plan. 6. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 7. Corrective action shall be complete by 5/28/12. <i>F282 POC accepted 5/29/12 Bltower RN / P. McArthur</i> F323 1. All hand rails used by residents were evaluated and issues addressed. 2. All residents are at risk to be affected by the alleged deficient	

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F 323	Continued From page 13 one of the surveyors when resting the arm on a handrail just inside the entry corridor on C Wing. In addition, some of hand rails in the corridors of resident units, including the areas outside room A-18 and A-19 as well as just inside the entry of C-Wing, were noted to have loose screws and/or were loosely secured to the walls and able to be moved with applied pressure. The observations of some handrails with rough, gouged and jagged handrails were confirmed by the Director of Maintenance during tour of the environment on the afternoon of 5/2/12.	F 323	practice. 3. Reeducation will be provided for staff regarding process for communicating environmental concerns.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	4. Random weekly audits to be done by maintenance director or designee to measure effectiveness of plan. 5. The Maintenance Director or designee to report results of plan to QAA committee monthly X 3 QAA committee to determine frequency of surveillance after this time. 6. Corrective action shall be complete by 5/28/12. <i>F323 POC accepted 5/29/12 BHWERN/AMetARW</i>	
		F431	1. Medication cart was locked upon notification. 2. There were no residents affected by the alleged deficient practice.	

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F 431	Continued From page 14 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys. The findings are as follows: Per observation on 05/03/2012 at 8:47 am the med cart on A-Wing was not locked and the medication nurse was in room A-5 with a resident who had fallen on the floor. S/he came out of the room on 2 occasions and did not secure the lock on the cart. At 9:00 am s/he wheeled the resident down to breakfast and the cart remained unlocked. During that time the Unit manager walked by the cart twice and did not notice that the cart was unlocked. The medication nurse returned to the cart at 9:04 am and locked it at that time. This is confirmed by the unit manager and medication nurse on 05/03/2012 at 9:04 am.	F 431	3. Nurses will be reeducated regarding policy for security of the med cart. 4. Random weekly audits will be completed by the DNS or designee to monitor effectiveness of the plan. 5. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 6. Corrective action shall be complete by 5/28/12. <i>F431 POC accepted 5/29/12 BHowe RN / P. McEARN</i>		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468	F468 1. All hand rails used by residents were evaluated and issues addressed.		

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F 468	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through staff interview the facility failed to assure that all hand rails used by residents were firmly secured to the walls. Findings include: Per observation, throughout the days of survey, some of hand rails in the corridors of all resident units, including the areas outside room A-18 and A-19 as well as just inside the entry of C-Wing, were noted to have loose screws and/or were loosely secured to the walls and able to be moved with applied pressure. The Maintenance Director confirmed these observations during environmental tour of the facility on the afternoon of 5/2/12.	F 468	<ol style="list-style-type: none"> 2. All Residents have potential to be affected by the alleged deficient practice. 3. Education to be provided to staff regarding process to communicate environmental concerns. 4. Random weekly audits to be done by the Maintenance Director or designee to monitor effectiveness of the plan. 5. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 6. Corrective action shall be complete by 5/28/12. <p><i>F468 POC accepted 5/29/12 BHowe RN / P. Meester RN</i></p>		